S. Hrg. 99-254

ADMINISTRATION PROPOSALS RELATING TO VA HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

JUNE 20, 1985

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
53-267 O WASHINGTON : 1985

S761-1

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CONTENTS

Page

Opening statement of Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs ... 3

Testimony of:

- Everett Alvarez, Jr., Deputy Administrator of Veterans' Affairs, Veterans' Administration, accompanied by Dr. John A. Gronvall, Chief Medical Director, Department of Medicine and Surgery; Marjorie R. Quandt, Assistant Chief Medical Director for Administration; and Donald L. Ivers, General Counsel ... 8
- Dr. Nancy M. Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office, Washington, DC, accompanied by Dorothy Amey, analyst; and Nina Shepherd, analyst ... 96
- A panel of health insurance representatives consisting of: Mary Nell Lehnhard, vice president, office of Government relations, Blue Cross and Blue Shield Association, Washington, DC; and Philip Briggs, executive vice president, Metropolitan Life Insurance Co., and representative of the Health Insurance Association of America, Washington, DC ... 128
- Richard L. Fogel, Director, Human Resources Division, General Accounting Office, Washington, DC, accompanied by James Linz, Group Director; David Baine, Associate Director; and Nancy Findley, Office of General Counsel ... 214

Written statement of:

- Hon. Strom Thurmond, a U.S. Senator from the State of South Carolina ... 7
- Everett Alvarez, Deputy Administrator of Veterans' Affairs ... 11
- Hon. George J. Mitchell, a U.S. Senator from the State of Maine ... 22
- Hon. Jeremiah Denton, a U.S. Senator from the State of Alabama ... 25
- Hon. Arlen Specter, a U.S. Senator from the State of Pennsylvania ... 61
- Dr. Nancy M. Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office ... 103
- Mary Nell Lehnhard, vice president, office of Government relations, Blue Cross and Blue Shield Association, Washington, DC ... 131
- Hon. Alan K. Simpson, a U.S. Senator from the State of Wyoming ... 174
- Philip Briggs, executive vice president, Metropolitan Life Insurance Co., and representative of the Health Insurance Association of America, Washington, DC ... 178
- Richard L. Fogel, Director, Human Resources Division, U.S. General Accounting Office, Washington, DC ... 220
- Bob Moran, associate legislative director, Paralyzed Veterans of America ... 283

Questions and answers:

Response of the Veterans' Administration to written questions submitted by:

- Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs ... 68
- Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs ... 73
- Arlen Specter, a U.S. Senator from the State of Pennsylvania ... 92
- George J. Mitchell, a U.S. Senator from the State of Maine ... 94

Response of the Congressional Budget Office to written questions submitted by:

- Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs ... 116
- Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs ... 121

Page

Questions and answers—Continued
- Response of Blue Cross and Blue Shield Association to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 188
- Response of the Health Insurance Association of America to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 192
- Response of the General Accounting Office to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 270

Letters to:
- Harry N. Walters, Administrator of Veterans' Affairs from Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, dated April 12, 1985 40
- Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, from Harry N. Walters, Administrator of Veterans' Affairs, dated May 7, 1985 48
- Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, from:
  - Donald L. Ivers, General Counsel, Veterans' Administration, dated April 24, 1985 194
  - Philip D. Brady, Acting Assistant Attorney General, Office of Legislative and Intergovernmental Affairs, dated April 26, 1985 208
  - Richard L. Fogel, Director, Human Resources Division, U.S. General Accounting Office, dated June 25, 1985 227
  - Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States, dated June 14, 1985 278
  - Paul S. Egan, deputy director, National Legislative Commission, The American Legion, dated June 11, 1985 279
  - David W. Gorman, assistant national legislative director for medical affairs, Disabled American Veterans, dated July 11, 1985 281
- Mary Nell Lehnhard, office of Government relations, Blue Cross & Blue Shield Association, from Philip S. Neal, Miller & Chevalier, Washington, DC, dated May 2, 1985 212

APPENDIX: The Committee on Veterans' Affairs recommended legislative provisions and report to the Committee on the Budget 285

ADMINISTRATION PROPOSALS RELATING TO VA HEALTH CARE

THURSDAY, JUNE 20, 1985

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SR-418, Russell Office Building, Hon. Frank H. Murkowski (chairman of the committee) presiding.

Present: Chairman Frank H. Murkowski, Senators Alan K. Simpson, Arlen Specter, Jeremiah Denton, Alan Cranston, George J. Mitchell, and John D. Rockefeller IV.

Senator **CRANSTON** [presiding]. The hearing will please come to order. I am opening the hearing because Senator Murkowski, the chairman, has been delayed. I also have a problem with two other committees that I am on that are having sessions that I have to attend briefly.

I am delighted to welcome the witnesses that are here today. Today's hearing is a critical element in the current debate over the future of the VA health-care system. As I stated during Senate consideration of the budget resolution for the next fiscal year, I sincerely believe that VA health care is at a watershed. Not since the early seventies when the Congress began the monumental task of rebuilding the VA health-care system in order to meet the needs of war-wounded Vietnam veterans has the system faced such a critical crossroads.

Decisions the Congress makes in the coming weeks and months will shape the VA health-care system for years to come, not only as to who the system cares for, but as to how that care is provided. Many courses of action are being proposed and advocated for the VA simply because they may result in reduced expenditures. Yet little, if any, thought seems to be given to the short- and long-term consequences of those actions.

This has occurred, I believe, because many of those developing and proposing alternatives have no real understanding of, involvement with, or commitment to the programs they are proposing to change. Their only real interest is in achieving a reduction of expenditures.

This certainly seems to be the case with reference to the VA health-care system where the confusion is really quite extraordinary as to the impact of various administration proposals designed by OMB to cut spending. I concur wholeheartedly that there is an absolutely critical need to restrain Federal spending so as to make major reductions in the deficit.

The VA budget of over $26 billion in the current fiscal year, including over $9 billion for medical programs, makes a very inviting target for budget cutters. However, it is our obligation as an authorizing and program oversight committee to seek to understand the consequences of those cuts before considering whether to impose them.

Turning to today's agenda, with reference to the proposed means test, there were two quite separate issues involved under this single rubric. First, how and in what form the VA will check on whether certain veterans are able to pay for the care they seek and need; and, second, whether the law should be changed so that veterans aged 65 and older are eligible for VA care only if they are unable to afford the care needed as determined under any means test established. It is entirely possible that the two issues can be resolved in ways different from the administration's proposals. And I believe it is important to acknowledge at the outset the existence of the two issues and different possible resolutions for them.

The threshold question is why, aside from the issue of extending the means test to those age 65 or over, is legislation needed at all to implement a means test. For nearly 5 years, the VA has had that statutory authority and has not exercised it. Is the agency now seeking only superfluous legislative authority?

On the merits of any particular means test, the biggest question for the committee is will imposing one result in a reduced demand for VA services which in turn will result in reduced appropriations needs for VA health care? It is clear that some participants in the ongoing debate, the budget cutters—OMB, CBO, and the Senate Budget Committee—believe that a means test will yield savings. However, they seek to ensure that outcome by prospectively reducing the VA's medical care appropriation, not by instituting the means test and making adjustments after evaluating its impact.

Other participants in the debate see no genuine cost savings associated with the means test, at least not in the foreseeable future.

The VA itself, judging from the public statements of the Administrator and the Chief Medical Director to date, as well as today's prepared testimony, is in the latter camp. This difference in viewpoints has yet to be adequately explained.

On the question of veterans age 65 and over being eligible for VA care without regard to their incomes, I remain deeply concerned that too little attention has been paid to the implications of any change in this area on other federally funded health-care programs, especially Medicare. Will a "savings" to the VA medical care account be offset by increased costs for Medicare? It seems quite clear that any VA savings will be largely offset by increased Medicare expenditures. And what will be the increased health-care spending for this care by virtue of the deductibles and co-payments that veterans thrown over to Medicare will have to shoulder?

With reference to health insurance reimbursement, I regard this proposal as a budget trick, pure and simple, and an inflationary one to boot. It would undeniably increase the cost of providing each unit of health care involved and it would conscript the health insurance industry into the service of the Federal Government as revenue collectors. In view of the clearly increased administrative costs for the same quantum of care, I continue to fail to see how this proposal makes good national health policy sense. I also continue to have significant concerns about the validity of many assumptions underlying this proposal.

With regard to the expiring authority to provide care on a fee basis for certain veterans in Puerto Rico, I want to note my profound disappointment with the most recent document submitted by the Agency in response to our committee's and the House committee's request for a comprehensive long-term plan for the health-care needs of eligible veterans in Puerto Rico. The VA's unabashed refusal to comply with the explicit request for a specific analysis of the health care needs of service-connected veterans in Puerto Rico is the most contemptuous response I have ever seen by the VA to a request for information from the authorizing committees.

In closing I note that various veterans' service organizations previously testified on May 7 regarding the issues before the committee today. In view of the elapse of time since those appearances and the very dynamic nature of the issues involved, I invite the organizations to submit updated or new testimony and, if they wish, to do so as soon as possible.

Mr. Chairman, I appreciated the opportunity to proceed since you were slightly delayed because I have two other committees I have to rush to before I come back here to participate in this hearing.

OPENING STATEMENT OF HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman MURKOWSKI [presiding]. Thank you, Senator Cranston. I certainly understand. I had a little problem with the dentist this morning, but I think he is going to end up having the upper hand. I won't prolong that conversation, however.

I appreciate your opening statement.

The purpose of the hearing this morning is to hear testimony on related veterans' health-care issues. I will withhold my opening statement in order to accommodate the presentation of a flag from the American Ex-Prisoners of War to this committee.

I would ask your indulgence as we proceed with that now. I do not think it is necessary to recess the hearing. We will include it as part of the hearing.

If you will excuse us, I would like Everett Alvarez to join us for the presentation.

Senator CRANSTON. Frank, if I could say one more thing.

Chairman MURKOWSKI. Yes.

Senator CRANSTON. I will be back around 10. And I would like to have a chance to question the VA.

Chairman MURKOWSKI. Surely. We would be very pleased, Alan.

Senator CRANSTON. Thank you.

Chairman MURKOWSKI. Now, we do not have much room here, gentlemen. So I am going to do as I am told. I assume we have somebody, Julie, who is in charge of this. Please instruct us accordingly.

Ms. **Susman**. Commander Galloway will make the presentation. He is right behind Senator Cranston.

[Presentation of flag.]

Chairman **Murkowski**. Thank you Commander Galloway. We are most appreciative. I accept this on behalf of the entire Committee on Veterans' Affairs. It is, indeed, a great honor. I am going to read into the record a statement acknowledging this presentation.

Thank you very much. It is our honor and pleasure.

Please just stay with me while I recognize you. You are welcome to participate in the hearing this morning.

Again, I want to say it is a privilege to accept the flag of the American Ex-Prisoners of War on behalf of the entire committee. The flag will be proudly displayed along with the other flags in our hearing room.

Commander, the flag of your organization is symbolic of your service and it is a reminder of the cost all prisoners of war have paid. It represents your past service in war and your present commitment to former prisoners of all wars. Those who have served our country while in enemy prison camps know the true meaning of sacrifice for our nation. You, yourself, endured the Bataan Death March and survived 3½ years of captivity before you regained your freedom.

I also recognize the presence of Earl Derrington, chairman of the Legislative Committee and past national commander; Chuck Williams, the national director at large for the eastern region; Orlo Natrig, the national director for the northeast region; Clydie Morgan, the national adjutant; and Warren Napoli, senior vice commander.

Congress formally recognized the American Ex-Prisoners of War by granting the group a charter in 1982. The 1980's have witnessed an increased awareness of the toll which captivity has upon the individual. Indescribable brutality, torture, and deprivation at the hands of their captors have long-term consequences in the lives of the combat veterans who were captured.

At Senator Denton's suggestion, the proposed Veterans' Administration Health-Care Programs Improvement Act of 1985, provides authority for the VA to counsel former prisoners of war in order to assist them in overcoming the psychological effects of detention or internment. This care will be provided even if the veterans' problems do not constitute a disability. This continues our efforts to refine and implement the concept of care for former prisoners of war which was advanced in Public Law 97-37.

Former prisoners of war from World War II and Korea comprise 99 percent of all living former prisoners of war. This group, along with veterans of World War I, may never have had the benefit of talking to a trained individual about their experiences. Years after their internment has ended, the lasting effects caused by their experiences can lead to chronic depression, if it remains unexpressed or unresolved.

I know that I speak for all of my colleagues in the Senate, and particularly those on the Senate Committee on Veterans' Affairs, when I indicate that this committee looks forward to continuing to work with you through the fine relationship which has been established with the American Ex-Prisoners of War.

Again, gentlemen, on behalf of the committee, we thank you for the presentation of this flag.

Mr. GALLOWAY. Thank you, Senator, for the time.

Mr. DERRINGTON. Thank you, Senator.

Chairman MURKOWSKI. If there is no objection, we will include this presentation in the hearing record.

Again, I would like to welcome all of you to the Senate Committee on Veterans' Affairs' legislative hearing on the issue relating to veterans' health care. Today we will focus on certain legislative proposals submitted by the administration.

Those proposals include the much-discussed means test; health-care eligibility for veterans aged 65 or over; third-party reimbursement, which has also received a good deal of attention; and health-care programs for veterans in Puerto Rico and the Virgin Islands.

The legislative proposals, relating to a means test which would apply to all non-service-connected veterans including veterans 65 years of age and older, and third-party reimbursement, are important policy issues which have been addressed during the past few months. These proposals, or modified versions of these proposals, would ensure, first, that the Veterans' Administration would continue to treat veterans, regardless of age, who cannot afford to pay for their care, and second, that veterans who pay for private health insurance would get the same benefit from such insurance coverage as nonveterans.

Our consideration of these proposals is certainly a responsible consideration and is relevant and timely in light of the attempts by the conferees and the Budget Committee to reach a consensus on the level of reconciliation savings which the Committees on Veterans' Affairs will be required to achieve.

The budget conferees have not yet agreed on what that level of savings will be, which puts us at a bit of a disadvantage. But our purpose today, and I want to emphasize this, is to give full and fair consideration to the administration's legislative proposals. Today's hearing is not—and I would emphasize—not, intended to rehash VA budget issues or come to any conclusions regarding specific savings the committee may or may not recommend.

Until we have received reconciliation instructions from the Budget Committees we will not know the amount of the savings we will be required to achieve. In order to make these decisions responsibly at the appropriate time, it is imperative that the Members of this committee look at reasonable legislative proposals which could achieve savings.

Thus, I have scheduled this hearing to gather the views of experts. I want to explore, fully, how these proposals will be implemented, the projected savings, and the impact each proposal would have on the quality of the veterans' health-care system, and, most importantly, on our Nation's veterans as a whole.

I am looking forward to hearing your views on the merits of these proposals and how they could be implemented in a fair and workable fashion.

In view of the attention that Senator Cranston gave in his opening remarks to the offsetting savings vis-a-vis the cost of implementing these cost-savings proposals, at least in principle, I would like you to direct your attention to the associated costs of implementation, so we can, again in some detail, determine whether there are cost savings, or if the administrative costs eat up the cost savings. That is within your areas of expertise, among others.

The implementation of a means test and reimbursement from private health insurers for the costs of health care provided by the Veterans' Administration to veterans with non-service-connected disabilities certainly would be major policy changes. However, our Federal deficit is running at a level of approximately $200 billion, depending on whose figures you believe, and the time has come when we must consider alternatives which would require the Veterans' Administration to allocate its resources in the most prudent and cost-effective manner.

If enacted, legislation for a means test and third-party reimbursement might result in significant budget savings. That is for us to explore today.

Regarding VA health care in Puerto Rico and the Virgin Islands, on May 24 of this year, the VA submitted to Congress its 10-year plan for meeting the needs of these veterans. The plan includes an extension of the VA's authority to contract for care for non-service-connected veterans, until the Veterans' Administration is able to expand its in-house capabilities for providing such care. The House has already taken action on the matter. Today we will explore the VA's proposal to extend the contract authority for 3 years, the cost implications of this extension, and alternatives to the proposal.

Senator Cranston has also indicated his attitude towards your response on the Puerto Rican VA health care situation. I would appreciate a detailed response directed at his area of concern.

I would also note that Senator Thurmond has a statement that will be entered in the record at this point.

PREPARED STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

MR. CHAIRMAN:

It is a pleasure to be here this morning to receive testimony on the legislative proposals pertaining to veterans health care submitted by the Reagan Administration.

Mr. Chairman, I commend you for scheduling hearings on these cost-savings measures. In view of the necessity to reduce the soaring Federal budget deficit, this Committee faces the difficult challenge of weighing competing demands for limited resources. For this reason, proper health care planning and the cost-effective delivery of medical services have never been more important to ensure that this Nation's commitment to our veterans is met through the provision of quality medical care. As the Committee considers these legislative proposals, the foremost concern should be that the Veterans Administration health care system continue to fulfill its primary mission of providing medical care to service-connected disabled veterans and to veterans unable to pay for needed medical care.

The legislative proposals which the Committee will consider today involve very important issues in the area of veterans health care. I look forward to the testimony we will hear today concerning the proposal of the Administration to revise the criteria for health care eligibility for nonservice-connected veterans 65 years of age or older. This proposal calls for a "financial means test" to determine eligibility for health care, and it is my concern that the implementation of any such test be fair and reasonable.

Mr. Chairman, I am particularly interested in the testimony we will receive today concerning the proposal of the Administration authorizing third party reimbursement from private health insurers. This legislative initiative would permit the Veterans Administration to collect from third party payers the reasonable cost of health and medical care furnished by Veterans Administration medical facilities to veterans with no service-connected disabilities who have private health insurance. As the Committee evaluates this proposal, close attention should be focused on the question of whether the projected savings to the Federal government from enactment of this measure justify the administrative costs of implementation.

Mr. Chairman, we have a distinguished list of witnesses present this morning to testify, and I join with you in welcoming them all. I look forward to a careful review of the testimony received today.

Chairman **Murkowski**. On behalf of the Members of the committee, I express my thanks in advance to each of the witnesses and I look forward to your testimony.

You may proceed in any manner in which you so desire, Everett.

TESTIMONY OF EVERETT ALVAREZ, JR., DEPUTY ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY; MARJORIE R. QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION; AND DONALD L. IVERS, GENERAL COUNSEL

Mr. **Alvarez**. Thank you, Mr. Chairman. I would like to submit my full statement for the record, if it is appropriate and summarize my remarks.

Chairman **Murkowski**. It will be entered in the record.

Mr. **Alvarez**. Thank you.

Mr. Chairman, we recently submitted to the Congress a draft bill that would revise eligibility for VA medical care.

Historically, the primary mission of the VA health-care system has been to furnish care to the service-connected and to veterans unable to pay for needed medical care. In 1970, Congress extended eligibility for VA care to veterans 65 and older without regard to financial need. In sharp contrast, legal eligibility of most non-service-connected veterans under 65 is based on their inability to defray the cost of needed VA care.

With the enactment of Public Law 96–330 in 1980 Congress, in effect, imposed on the VA the requirement that we implement a means test on non-service-connected veterans under the age of 65.

The laws differing treatment of veterans on the basis of age raises a serious issue of equality. The VA may only provide medical care to the extent facilities and resources are available. As our veteran population is aging, the number of veterans who will be eligible for medical care is increasing. In our view, fairness dictates that age alone should not be the basis entitling one to VA care. Rather, we believe the VA resources should be targeted to those non-service-connected veterans who lack the financial means to obtain such treatment elsewhere, regardless of age.

Our proposal, accordingly, would overcome this inequity by authorizing the VA to determine that veterans over the age of 65 who are not otherwise eligible for, and seek VA care, have a financial as well as a medical need to receive that care.

We believe that these issues should be brought to the attention of the Congress and other interested parties and should receive a complete and thorough review. To implement a means test without resolving the age 65 issue would place the VA in the position of providing medical care to certain veterans solely on the basis of age, while subjecting veterans under the age of 65 to a financial means test.

Under our proposal there would be no change in the eligibility or treatment of service-connected veterans. Furthermore, the proposal would not alter the role the VA has played in providing medical care to other groups of veterans, including pensioners, certain groups and certain veterans exposed to toxic substance, former POW's and generally veterans with income and liquid assets totaling less than $15,000 as proposed.

We are confident that enactment of this proposal would assure fairness and permit the VA health-care system to be more responsive to those veterans with the greatest need for and highest claim to its services.

Let me also emphasize that we submitted this legislative proposal solely on the basis to achieve equity and not to obtain cost savings.

Mr. Chairman, we have also recently submitted a draft bill that would authorize the United States to collect the cost of medical care furnished by the Veterans' Administration to veterans with no service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care.

The measure would prohibit, prospectively, the exclusion of payments to the Veterans' Administration if the cost of care would be covered when furnished by private facilities. The proposed legislation would not apply to Medicare, Medicaid, or group income protection plans that pay a fixed sum per day, week, or month while a beneficiary is disabled.

It is also specifically provided that the amount recoverable by the Government may not exceed the maximum amount specified by the law of any State or political subdivision, or in the policy.

The insurance company will not be responsible for any deductible or copayment requirements that would be required from the policyholder if care was provided in the private sector.

Mr. Chairman, two recent reports, one by the GAO and the other by the Grace Commission, have recommended enactment of the type of legislation we have proposed. We strongly agree with their recommendations that this legislation is necessary to void exclusionary clauses in health insurance policies, and that the imperative of reducing the size of the Federal budget makes its passage more important than ever before.

Lastly, as you know, Mr. Chairman, the special contracting authority applicable to U.S. territories, possessions and the Commonwealth of Puerto Rico will expire on September 30, 1985. We recommend that Congress extend that authority for an additional 3 years. This will give the VA and the Congress sufficient time to develop an equitable response to the health-care needs of veterans in Puerto Rico and the Virgin Islands and would prevent any unnecessary hardships.

Mr. Chairman, that concludes my statement. Members of my staff and I will be pleased to answer any questions you or members of the committee may have. Thank you.

Chairman MURKOWSKI. Thank you, Mr. Alvarez.

[The prepared statement of Everett Alvarez, Deputy Administrator of Veterans' Affairs, Veterans' Administration, follows:]

PREPARED STATEMENT OF EVERETT ALVAREZ, DEPUTY ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to appear before you to urge support for two major VA proposals--to revise VA medical care eligibility and to authorize third party reimbursement.

REVISED ELIGIBILITY FOR VA MEDICAL CARE

Mr. Chairman, we recently submitted to the Congress a draft bill that would revise eligibility for VA medical care. Let me set that proposal in context.

Historically, the primary mission of the VA health care system has been to furnish care to service-connected disabled veterans and to veterans unable to pay for needed medical care. In 1970, however, Congress extended eligibility for VA hospital and nursing home care to veterans 65 years of age and older, without regard to financial need. In sharp contrast, legal eligibility of most nonservice-connected veterans under 65 is based on their inability to defray the cost of needed VA care.

The law's disparate treatment of nonservice-connected veterans on the basis of age raises a serious issue of equality. VA may only provide medical care to nonservice-connected veterans to the extent facilities and resources are available. Demographic projections indicate that the number of veterans who will be eligible for care as our veteran population ages is increasing significantly. Fairness dictates that age alone should not be the basis entitling one to VA care. Rather, VA resources should be targeted to those nonservice-connected veterans who lack the means to obtain such treatment elsewhere, regardless of age.

Our draft bill, accordingly, is intended to overcome this inequity. Our proposal would amend title 38 to authorize VA to determine that nonservice-connected veterans over the age of 65 who are not otherwise eligible for, and seek, VA care have a financial as well as a medical need to receive that care. This change would enable VA to sustain the quality of care provided to the most deserving veterans--those with service-connected disabilities and those without resources to defray all or part of their health care expenses.

The change would also clarify and extend a framework which Congress provided for in 1980 when it enacted Public Law 96-330 and deleted provisions of law prohibiting VA from looking behind a veteran's assertion of financial need. Thus, the bill would specifically provide for the Administrator to promulgate regulations identifying the conditions under which veterans may be considered unable to defray medical expenses. It would also establish in law that a nonservice-connected veteran whose total income and assets, as defined in the improved pension program, is below an eligibility level set at twice the VA pension rate--a level currently of just under $15,000 for a veteran with one dependent--would be deemed unable to defray the cost of any needed health care.

Under this proposal, VA would continue to fulfill its primary mission of care for service-connected veterans. Furthermore, this proposal would not alter the role VA has played in providing medical care, within the limits of VA facilities, to other groups of veterans:

(1) veterans who were prisoners of war;

(2) veterans of the Spanish-American War, Indian Wars, Mexican border period, or of World War I;

(3) Vietnam War veterans exposed to certain herbicides during military service;

(4) certain veterans exposed to ionizing radiation during military service; and

(5) VA pensioners.

Enactment of this bill would enable VA to develop a fair, effective screening system to help assure that those veterans with greatest need--the service-connected and the financially disadvantaged--can avail themselves of VA care. Regulations, provided for in the bill, would establish the circumstances under which a veteran, whose income and asset value exceed the proposed twice-pension-rate standard, would receive VA care. The central elements of this system, as applied to veterans with means above that standard, would provide for the following:

(1) In most cases, these veterans would not be eligible for VA health care unless the veteran's out-of-pocket medical expenses exceeded certain amounts.

(2) These out-of-pocket expenses, called the "expected medical expense contribution", would be an increasing share of the amount by which the total of the veteran's family income and asset value exceeds the eligibility level. This share would increase progressively with income, requiring higher income veterans to finance a larger amount of their medical expenses before entering the VA system.

(3) In emergency or extraordinary circumstances, these veterans could receive care in the VA system but would be billed for their share of the cost up to their expected medical expense contribution.

(4) In exceptional and unusual circumstances, the Administrator could waive in whole or in part the veteran's expected medical expense contribution in order to avoid substantial hardship.

Enactment of this bill and implementation of a screening mechanism would enable us to assure that VA health care resources are targeted to those most in need. We project that the proposal would result in a lower rate of growth in VA's medical care and construction budgets than otherwise would be needed, while at the same time insuring the availability of resources to sustain a quality health care system for veterans.

We are confident that enactment of this proposal would assure fairness and permit the VA health care system to be more responsive to those veterans with the greatest need for, and highest claim to, its services.

THIRD PARTY REIMBURSEMENT

Mr. Chairman, we have recently submitted to the Congress a draft bill that would authorize the United States to collect the cost of medical care furnished by the Veterans Administration to veterans with no service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care.

The measure would address those situations where private health insurance programs and policies now exclude payment to the Federal Government for the cost of medical treatment furnished while permitting payment for similar services to health care providers in the private sector. If enacted, it would enable the United States to recover the reasonable value of medical services provided to veterans with no service-connected disabilities. The reimbursement would be for outpatient or inpatient medical, hospital, or nursing home care provided in a Veterans Administration facility to the extent that the veterans are entitled to care, or reimbursement for the cost of care under a health insurance policy or contract. It would also prohibit, prospectively, the exclusion of payments to the Veterans Administration for outpatient or inpatient medical, hospital, or nursing home care for treatment of such veterans from coverage under these policies or contracts, if the care would be covered when furnished by private facilities.

The proposal is similar to S. 759, 96th Congress (H.R. 3475), which would have authorized recovery from health insurance, workers compensation, no-fault insurance and crime-victims' acts. In the 97th Congress, a bill similar to S. 759, but with provisions relating to health insurance deleted, was enacted as section 106(a)(1), Pub. L. No. 97-72, now codified as section 629, title 38, United States Code.

The current proposal would complement those areas already provided for in 38 U.S.C. § 629 and the Federal Medical Care Recovery Act, 42 U.S.C. § 2651 et seq. which authorize recoveries under no-fault plans, workers compensation laws, crime-victim's acts or in tortious circumstances.

The proposed legislation would not apply to Medicare and Medicaid benefits. Payments under group income protection plans that pay a fixed sum per day, week, or month while a beneficiary is disabled would also not be subject to Veterans

Administration reimbursement. It should also be noted that the proposal is not an attempt to place the Government in a better position vis a vis reimbursement from private health insurance than that occupied by private health care providers. It is specifically provided that the amount recoverable by the Government may not exceed the maximum amount specified by the law of any State or political subdivision, or in the policy. Moreover, the insurance company will not be responsible for any deductible or copayment requirements that would be required from the policyholder if care was provided in the private sector.

Mr. Chairman, two recent reports, one from an arm of the Congress, the other from an Executive commission, have recommended enactment of the type of legislation we have proposed. In the most recent report, dated February 26, 1985, the General Accounting Office concluded that if similar legislation had been in effect in Fiscal Year 1982, the Government could have recovered at least $98 million to $284 million from private health insurance with minimal impact on health insurance premiums, estimated to increase from $0.93 to $2.69 per year per policy holder.

The President's Private Sector Survey on Cost Control, commonly known as the Grace Commission, has also recommended collecting from third party payers the cost of care provided in Government medical facilities. In its Task Force Report on Federal Hospital Management, the Commission recommended that the Veterans Administration be given equal status with private health care providers in this regard. To that end, it proposed that Congress enact legislation to prohibit exclusionary roadblocks that currently prevent payment of such claims. We strongly agree with the Commission that this legislation is necessary to void exclusionary clauses in health insurance policies, and that the imperative of reducing the size of the Federal budget make its passage more important than ever before.

It is estimated that enactment of this proposal could result in reimbursements ranging from $65 million in Fiscal Year 1986 to $285 million in Fiscal Year 1990.

HEALTH CARE IN PUERTO RICO/VIRGIN ISLANDS

You have also requested our views on the provision of VA care in Puerto Rico and the Virgin Islands. As you know, Mr. Chairman, the special contracting authority applicable to U.S. territories, possessions and the Commonwealth of Puerto Rico will expire on September 30, 1985. Under that provision, 38 U.S.C. § 601(4)(C)(v), VA has authority to contract for needed hospital care and medical services to obviate the need for hospital admission for veterans. This special authority to contract for care in noncontiguous States is subject to a restriction limiting the total volume of care to a level consistent with that provided in the 48 contiguous States. Under current law, the application of that restriction in Puerto Rico and the Virgin Islands may be waived by the Agency if necessary to avoid hardship.

We recommend that Congress extend for an additional three years, through September 30, 1988, the special contract authority to provide care to eligible veterans in Puerto Rico, the Virgin Islands and other territories. This extension would give the VA sufficient time to complete the complex planning process associated with developing an equitable response to the health care needs of veterans in Puerto Rico and the Virgin Islands. The proposal is based on a recommendation in the VA's reports to Congress on this issue, and is needed to prevent any unnecessary hardship on veterans. This extension would also give the VA and Congress an adequate opportunity to achieve mutual goals with respect to the veterans of Puerto Rico and the Virgin Islands. The estimated cost of this proposal is $9.2 million for Fiscal Year 1986, $9.4 million for Fiscal Year 1987, and $9.6 million for Fiscal Year 1988. The three-year cost is estimated at $28.2 million.

Finally, Mr. Chairman, as you consider pending legislation, we would note that the VA has sent Congress a number of draft bills for the Committee's consideration. Many of these bills would improve Agency programs and enable us to achieve improvements in VA provisions of services. We urge you to take up and adopt these proposals.

Mr. Chairman, that concludes my statement. Members of my staff and I will be pleased to answer any questions you or members of the Committee may have.

Chairman **Murkowski**. We have been joined by some of our colleagues. Senator Mitchell from Maine, Senator Denton, and Senator Rockefeller.

We have had a presentation of this flag from the Ex-Prisoners of War as a special contribution to this committee. I think the significance of that and the organization represented by the Ex-Prisoners of War is a significant contribution, not only by that organization, but as a reminder of the obligation that this committee has to those that gave so much to their country. And, Senator Denton, I am sorry that you could not have been here during that presentation.

Senator **Denton**. I was over at the Armed Services Committee meeting. Sorry I was not here.

Chairman **Murkowski**. The Veterans' Administration panel is before us. If you have any statements that you would like to make, it would be appropriate at this time, and I will interrupt the hearing to accommodate you.

Senator **Mitchell**. Mr. Chairman, thank you. I do have a statement, but in the interests of time and permitting us to proceed with the hearing I will ask that my statement be inserted in the record at the appropriate point.

Chairman **Murkowski**. Your entire statement will be entered in the record.

[The prepared statement of Hon. George J. Mitchell, a U.S. Senator from the State of Maine, follows:]

PREPARED STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

I welcome the witnesses to this morning's hearing on proposals relating the Veterans Administration health care policy. Those proposals: (1) would require the implementation of a means test for nonservice-connected veterans, regardless of age, for VA medical care and (2) would authorize the VA recover the costs of VA care to privately insured veterans for nonservice-connected medical conditions.

Those proposals were included in President Reagan's Fiscal Year 1986 Budget that was submitted to Congress in February. At that time, I expressed my reservations about the proposals; both in this Committee and with the other Minority members of the Committee in a March 6 letter to the Chairman and Ranking Member of the Senate Budget Committee. I still have serious reservations about the proposals. I hope the testimony from today's witnesses will assuage those reservations.

I hope the witnesses will be able to address these points during their testimony.

- What cost savings could be realized by enactment of these proposals? And is it appropriate public policy to pursue these cost savings in the area of veterans health care?

- Will any cost savings in the VA system be matched by increasing costs in other Federal health care programs, chiefly the Medicare system?

- Are the proposals fair? Can they be administered? Will they achieve the goals they aspire to?

I look forward to receiving the testimony of today's witnesses on these proposals, although I apologize in advance for not being able to stay for the entire hearing. The Finance Committee, of which I am a member, is holding hearings today on the issue of tax simplification. Nevertheless, I will review the written testimony carefully.

In addition to the questions I ask this morning, I anticipate having written questions following the hearing.

I also look forward to working with the distinguished Chairman, the Distinguished Ranking Member, and the other members of the Committee in the coming weeks as we proceed on the proposals before us today.

Chairman MURKOWSKI. Senator Denton.

Senator DENTON. I prefer to do the same thing in order to participate as long as possible in the exchange of information and opinions, Mr. Chairman.

Chairman MURKOWSKI. Thank you, Senator Denton.

[The prepared statement of Hon. Jeremiah Denton, a U.S. Senator from the State of Alabama, follows:]

PREPARED STATEMENT OF HON. JEREMIAH DENTON, A U.S. SENATOR FROM THE STATE OF ALABAMA

Mr. Chairman, today's hearing will deal with controversial issues, notably proposals for means tests and third party reimbursements for VA medical services. I thank the Chairman for holding the hearing to give us the chance to hear from the experts on the subjects. I am especially glad to see my good friend Ev Alvarez, the Deputy Administrator of Veterans Affairs, who is here to testify on behalf of the VA.

The American taxpayer is foremost in the minds of members of Congress. I know that is the case for this Senator. Because of that concern, this Committee must ensure that the VA minimizes its costs while continuing to provide high quality care to the veterans who need it. The only way that we can continue to do that at a time of budget constraints is to do it in a more efficient and more effective manner.

The number of older veterans, who place special demands upon the VA) is predicted to skyrocket in the 1990s. In order to provide for the older veterans who must have care, the Committee will have to reaffirm that combat and service-connected veterans will receive priority treatment. We must also see that care is provided to veterans who otherwise

WOULD BE UNABLE TO OBTAIN HEALTH CARE. TWO WAYS THAT HAVE BEEN PROPOSED TO ASSIST THE VA IN DOING THAT ARE TO BE CONSIDERED TODAY.

THE FIRST ISSUE BEFORE THE COMMITTEE IS WHETHER TO REQUIRE A MEANS TEST TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE. ONE OF OUR GOALS IS TO ENSURE THAT THE VETERANS WHO ARE MOST IN NEED, THE SERVICE-CONNECTED AND POOR, WILL RETAIN THE HIGHEST PRIORITY FOR CARE. THE IDEA THAT "ALL OLDER VETERANS MUST GET FREE CARE" IS ONE THAT WE NEED TO DEAL WITH.

THERE ARE MANY VIETNAM VETERANS OUT THERE WHO HAVE SERIOUS SERVICE-CONNECTED AND COMBAT-RELATED DISABILITIES, BUT WHO ARE STILL YOUNG. WE MUST NOT ALLOW THEM, AS A MATTER OF POLICY, TO BE DISPLACED BY A VETERAN WITH NONSERVICE-CONNECTED DISABILITIES WHO HAS A HIGHER PRIORITY JUST BECAUSE HE IS OVER AGE 65. OLDER VETERANS SHOULD HAVE THE RIGHT TO VA CARE IF THEY REALLY NEED IT. WE NEED TO AFFIRM, HOWEVER, THAT AGE IS NOT, IN ITSELF, A DISABILITY.

JUST BECAUSE A VETERAN TURNS 65 DOES NOT MEAN THAT HE IS SUDDENLY AND TOTALLY DISABLED. SHOULD THE MEANS TEST BE IMPLEMENTED, OLDER VETERANS WOULD HAVE TO SHOW AN ACTUAL DISABILITY TO QUALIFY FOR A VA PENSION. AS A 61 YEAR OLD VETERAN, I BELIEVE THAT I AM FAIRLY QUALIFIED TO SAY THAT

ONE DOES NOT AUTOMATICALLY FALL APART THE CLOSER ONE GETS TO HIS 65TH BIRTHDAY. IT MAY TAKE A FEW MORE YEARS FOR THAT TO HAPPEN.

I KNOW THAT THERE ARE THOUSANDS OF OLDER VETERANS WHO ARE PERFECTLY HEALTHY, AND WHO WOULD NOT WANT TO DISPLACE A COMBAT OR SERVICE-CONNECTED VETERAN IN A VA MEDICAL FACILITY. I AM IN FAVOR OF QUALITY HEALTH CARE FOR ALL VETERANS, BUT WE MUST NOW TARGET THAT CARE MORE EFFICIENTLY AND MORE EFFECTIVELY TO BE SURE THAT WE ADEQUATELY SERVE THE GROWING NUMBER OF OLDER VETERANS.

THE COMMITTEE SHOULD LOOK AT THE CONCEPT OF A FAIR AND EQUITABLE MEANS TEST. WE MAY OR MAY NOT WANT TO DO IT, BUT WE NEED TO LISTEN TO THE TESTIMONY SO WE CAN MAKE AN INFORMED DECISION.

ANY TEST MUST BE ADMINISTRATIVELY MANAGEABLE, AND NOT UNDUELY BURDENSOME FOR THE VETERAN. THE PURPOSE OF THE MEANS TEST WOULD BE TO ALLOW MORE OF THE CRITICALLY NEEDED HOSPITAL BEDS TO BE ALLOCATED FOR SERVICE-CONNECTED VETERANS AND COMBAT DISABLED VETERANS, WITH NONSERVICE-CONNECTED VETERANS HAVING THE THIRD PRIORITY. I DO NOT BELIEVE MANY PEOPLE WOULD ARGUE THE POINT THAT MILITARY PERSONNEL WHO ARE INJURED WHILE SERVING THEIR COUNTRY SHOULD RECEIVE FIRST ATTENTION. THE VA ALREADY HAS THE AUTHORITY TO IMPLEMENT

A MEANS TEST FOR VETERANS UNDER 65. THE ADMINISTRATION'S PROPOSAL WOULD LIFT THAT RESTRICTION FOR OVER AGE 65 VETERANS.

THE SECOND ISSUE THE COMMITTEE IS STUDYING IS THE COLLECTION OF THIRD PARTY REIMBURSEMENTS FROM PRIVATE HEALTH INSURERS FOR CARE PROVIDED BY THE VA TO VETERANS WITH PRIVATE HEALTH INSURANCE COVERAGE. IF VETERANS ARE PAYING GOOD MONEY TO AN INSURANCE COMPANY FOR HEALTH CARE, AND THEN ARE RECEIVING CARE FROM THE VA, THEN IT MAY NOT BE UNREASONABLE FOR THE INSURANCE COMPANIES TO REIMBURSE THE VETERANS ADMINISTRATION, PROVIDING THAT INSURANCE PREMIUMS DO NOT INCREASE CONSIDERABLY.

I KNOW, FOR EXAMPLE, THAT THIRD PARTY REIMBURSEMENT IS WORKING WELL IN ALASKA, THE HOME STATE OF OUR DISTINGUISHED CHAIRMAN. IN ADDITION, THE GENERAL ACCOUNTING OFFICE HAS FOUND THAT THERE ARE NO LEGAL OR ADMINISTRATIVE PROBLEMS THAT PREVENT THE ENACTMENT AND IMPLEMENTATION OF THE PROGRAM. THERE ARE MANY POSITIVE REASONS FOR THE COMMITTEE TO INVESTIGATE REIMBURSEMENT , BUT THERE MAY ALSO BE ARGUMENTS AGAINST IT. I AM SURE THAT WE WILL HEAR THE ARGUMENTS ON BOTH SIDES.

I LOOK FORWARD TO THE TESTIMONY. I BELIEVE THAT WE WILL LEARN A LOT FROM THE DISTINGUISHED WITNESSES.

THANK YOU, MR. CHAIRMAN.

Chairman MURKOWSKI. Senator Rockefeller.

Senator ROCKEFELLER. I would have the same request, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much, gentlemen, for your contribution of your time. We will proceed into the questions that we have.

It is my understanding that under the administration's means test proposal, a non-service-connected veteran whose total income and assets is below an eligibility level set at twice the VA pension rate—that is approximately $15,000 for a veteran with one dependent—would be deemed unable to defray the cost of care. Is that the position of the administration?

Mr. ALVAREZ. Mr. Chairman, that was in the proposal. And the level, $15,000, was, is one that was set forth to put on the table for discussion. But certainly the committee certainly has the right to look into that and adjust accordingly. I think the whole purpose was to lay something on the table initially.

Chairman MURKOWSKI. Sure, as a starting point. But I am curious to know if that is how you gentlemen and Ms. Quandt feel about that level, since you would have to administer it.

Mr. ALVAREZ. Yes, sir.

Chairman MURKOWSKI. I would appreciate your reactions.

Ms. QUANDT. It is a level that will accommodate most of the non-service-connected veterans who would be applying to us. And it is a level at two times pension level, allowing for a veteran with one dependent, which in our opinion is fair.

Chairman MURKOWSKI. So the current pension level is about $7,500?

Ms. QUANDT. That is right, $7,500.

Chairman MURKOWSKI. It has been expressed to me—and I cannot remember just who or where I heard it, but I probably could generalize and say I heard it from a number of representatives of the various veterans groups—that they felt that the $15,000 level was too low.

Mr. ALVAREZ. We have also, Mr. Chairman, we have also heard the same. We have heard other suggested levels, higher level, $20,000, $25,000, as being fair.

As Ms. Quandt indicated, this is one that we have looked at for quite a while. In basis of fairness we proposed this several times, this has come up several times in the past. And made the decision to go ahead with this level figure to get——

Chairman MURKOWSKI. OK. So you are sticking by the $15,000 level?

Mr. ALVAREZ. At this point, yes, sir.

Chairman MURKOWSKI. OK. How long will it take to fully implement the administration's means test proposal?

Ms. QUANDT. Assuming that we have agreement in the executive branch as to the technical details and that we will follow the policy of publication in the Federal Register which allows 30 to 60 days for notice and public comment, we would believe that 90 days after a bill is signed by the President we can implement it.

Chairman MURKOWSKI. In the administration's means test proposal there is a rather elaborate requirement for non-service-connected veterans whose income and assets exceed the proposed eligibility threshold. How does the VA propose to implement and monitor these expected medical expense contributions, and what would be the extent and costs of necessary administrative charges?

Mr. **Alvarez**. Ms. Quandt.

Ms. **Quandt**. Assuming that the veteran who applies for care, non-service-connected, has an income above the threshold he will have to meet a sliding scale to figure his expected contribution. It would be necessary for that veteran when he applies to provide us with copies of his expenses that he has paid or any other payments in his behalf for health care.

Chairman **Murkowski**. Is this similar to the private sector when you have to submit expenses for reimbursement?

Ms. **Quandt**. It would be similar if you were, let's say, a Medicare patient and you had another type of insurance you would have to show what was covered by another type of insurance. It is to that extent similar to a private citizen attempting to regain that from various benefits. They do have to prove that.

Chairman **Murkowski**. With the cost of living variation around the country—and I do not want to reflect on the State of Alaska, but Alaska and several other States, including Hawaii have substantially higher costs of living, and correspondingly higher income levels are reflected in these geographical regions—your proposed means test could have a greater impact on those areas because the income threshold of $15,000 would make many veterans ineligible for health care. Can anything be done about this potential inequity? For example, the Federal Government gives a 25-percent tax free salary adjustment to Federal employees in my State. That is just a reality.

Dr. **Gronvall**. Mr. Chairman, there is a provision in the proposal that the Administrator under certain circumstances could waive some or all of the required contribution. The definition of what those circumstances would be would have to be developed. But I think the kind of situation that you describe of the unique geographic financial problem might be one of the things that would allow a waiver by the Administrator.

Chairman **Murkowski**. Ms. Quandt.

Ms. **Quandt**. Mr. Chairman.

Chairman **Murkowski**. Yes?

Ms. **Quandt**. We would assume in States such as Hawaii and Alaska or such urban areas as the New York area where the cost of living is higher, where the expenses are higher, that those deductions would bring those non-service-connected veterans into eligibility. For example, the $900 a day per diem in Alaska would offset those who potentially would be considered ineligible.

Chairman **Murkowski**. In 1980, Public Law 96-330 was enacted. I think Senator Cranston—and you may correct me—was responsible for that law, which basically instituted the concept of a means test, but it was never administered by the VA. Could you give us an explanation of why——

Mr. **Alvarez**. Yes. Ms. Quandt.

Chairman **Murkowski** [continuing]. It was not instituted by VA when it became law?

Mr. **Alvarez**. Ms. Quandt can answer that.

Senator CRANSTON. That proposal actually came from the House committee.

Chairman MURKOWSKI. Did it?

Senator CRANSTON. Yes.

Chairman MURKOWSKI. I stand corrected.

Ms. QUANDT. There were numerous attempts at writing a regulation to implement the law. There were some differences within the agency. At that point we then had some differences within the executive branch. And after we finally did reach an accommodation as to a regulation that could be published, at that point in time the next two anticipated legislative changes came about and it was decided and determined to hold that regulation for publication.

We have one——

Chairman MURKOWSKI. Is that customary within the VA when Congress passes a law that they just decide that they are not going to institute it?

Ms. QUANDT. No, sir, that is not. One of——

Chairman MURKOWSKI. How come this happens to be an exception?

Ms. QUANDT. One of the real problems has been the, let's say, environment of this piece of legislation. It was a very unpopular piece of legislation with the service organizations and our constituents.

Mr. ALVAREZ. Mr. Chairman.

Chairman MURKOWSKI. Well, then it is Congress' obligation, if the legislation is unpopular, to do away with it if Congress had previously passed it. I am not satisfied we are getting a satisfactory answer. If Congress passed a law, it is up to the appropriate agency to implement it. If people do not like the law then it is the responsibility of Congress to change it. But just to ignore it——

Mr. ALVAREZ. We, Mr. Chairman, we, as Ms. Quandt explained, have been trying for a couple of years to get an agreement, an agreeable type of a test set up so that we could implement it. When we finally reached the point about a year ago we realized that the fairness issue that was raised in our proposal here, and we feel that, we felt at that time to hold off and seek changes to the law through our proposed legislation basically it is the age 65 issue, that is the question here, gave us difficulty.

Ms. QUANDT. Mr. Chairman.

Chairman MURKOWSKI. Well, that was 4 or 5 years to make that determination. It seems like a long time.

Ms. QUANDT. Mr. Chairman, while we may not have implemented that, we did amend our application form. We have always retained the old inability to pay. And we amended our application form which specifically alerted non-service-connected veterans to those facets or facts which should be considered when applying for care.

Chairman MURKOWSKI. Are you going to implement it now?

Mr. ALVAREZ. At this point we are asking that the legislation be changed on the issue. And on that basis until we decide——

Chairman MURKOWSKI. All right, I want to make sure I understand this. You want the legislation changed?

Mr. ALVAREZ. Yes, sir.

Chairman **Murkowski**. You have the authority to implement it now. And you want it changed to reflect the threshold? Is that part of it? You suggested a threshold of $15,000.

Mr. **Alvarez**. The $15,000 was a suggestion. Our basic, our basic concern is the age 65 level and the fairness issue associated with that level.

Chairman **Murkowski**. Well, tell me specifically what you need changed in the law in order to implement it? Is it the 65-year-old provision?

Ms. **Quandt**. The major change would be that the exclusion for 65-year-olds from consideration for income for non-service-connected veterans would be changed.

Chairman **Murkowski**. OK. Let's state that so everybody can understand it. The only change that you are proposing to make before implementation of a means test is the provision for 65-year-olds. Give us specifically your understanding of what that change will be, so we all understand.

Ms. **Quandt**. The non-service-connected veteran who is 65 or older will be required to state that he does or does not have the means to pay for care.

Chairman **Murkowski**. A service-connected veteran will?

Ms. **Quandt**. Will not be involved.

Chairman **Murkowski**. Will not be involved at all.

Ms. **Quandt**. Service-connected are exempt, as are other classes of veterans.

Chairman **Murkowski**. That is what you are asking this committee to move as legislation, right?

Mr. **Alvarez**. Yes, sir.

Chairman **Murkowski**. OK. The issue of qualification is one that concerns me because there have been suggestions that it would be embarrassing or demeaning to the veteran to go through whatever administrative process is going to be designed here. How does the VA propose to insure that that does not occur?

Ms. **Quandt**. Our proposal, Mr. Chairman, would be that we convert to another portion of our application for care to what we call a pension-like form which will ask that veteran his income, assets, debts, net worth, for himself and his family.

Chairman **Murkowski**. This is similar to what has to be done for VA pension?

Ms. **Quandt**. Right. We will move to that type of a questionnaire, applying that to hospital care.

Chairman **Murkowski**. What is the attitude of the service organizations toward that concept? Do you know?

Mr. **Alvarez**. We would have to let the service organizations, I think, address that individually because we have found a varying opinion amongst the organizations.

Chairman **Murkowski**. But is there a consistency in the pension procedure at least?

Mr. **Alvarez**. Yes, sir.

Ms. **Quandt**. Yes, sir.

Chairman **Murkowski**. It is no more difficult than applying for a VA pension. Is that right?

Ms. **Quandt**. No.

The other matter, Mr. Chairman, is that historically at one time when we went into the means test years ago before it was given up, we made certain that our admitting areas were designed for privacy for the purpose of intake. So there should be no questioning of a veteran about his net worth in front of the public.

Chairman MURKOWSKI. What is the cost of implementing this proposal?

Ms. QUANDT. We anticipate it will require $6 million in personnel costs.

Chairman MURKOWSKI. How much of it is automated?

Ms. QUANDT. In fiscal 1986.

I beg your pardon?

Chairman MURKOWSKI. Is it not an automated process in the sense that——

Ms. QUANDT. At the present time it would be automated in 59 facilities. And those are the facilities that have our distributed hospital computer network. Otherwise, there is——

Chairman MURKOWSKI. So you figure an increase of $6 million in personnel costs?

Ms. QUANDT. That is at this point a cost that will be absorbed within the agency because of other productivity changes and manpower changes.

Chairman MURKOWSKI. So it does not represent then a direct cost?

Ms. QUANDT. No.

Chairman MURKOWSKI. What is the direct cost?

Ms. QUANDT. It would be $6 million.

Chairman MURKOWSKI. Well, you just said that was not a direct cost because it——

Ms. QUANDT. It is absorbed through productivity.

Chairman MURKOWSKI [continuing]. Was going to be assimilated in. What?

Ms. QUANDT. It is absorbed through productivity, increased productivity.

Chairman MURKOWSKI. So you increase your productivity another beat. So you do not incur direct—I want to know whether you are incurring a direct cost or not. You say no?

Ms. QUANDT. I say no.

Chairman MURKOWSKI. OK. What are the savings?

Mr. ALVAREZ. We have not estimated any savings in 1986. In the out-year we anticipate cost avoidances but we were not looking at in-year savings.

Chairman MURKOWSKI. What are your cost avoidances?

Ms. QUANDT. The cost avoidances are cost avoidances of the person, of the patients that are considered—I'll use the term "in line", since someone the other day asked me what "queue" was.

Chairman MURKOWSKI. Using the term what?

Ms. QUANDT. Are the cost avoidance for the patients who are waiting in line or in the queue for care. We care for 2.9 individual veterans in a fiscal year. There—2.9 million. There are essentially 11 million veterans in the base of other eligibles or with income of $15,000 a year or lower. So for any one veteran who is taken out of our care pattern because his income is above that there are at least one or two other veterans waiting possibly for care.

Chairman **Murkowski**. OK. I am a little confused though. You tell me that there is no direct cost increase as a consequence of implementing the means test. You can do it 90 days after enactment. But it is fuzzy as to what we save. If we do not save anything why are we going through the exercise? I mean, there has got to be some relationship to purpose. I think we need to highlight that a little if indeed there is something to highlight.

Ms. **Quandt**. Mr. Chairman, it would come back to the matter of equity and fairness. There have been reports recently from other branches of the Government and other, other research groups, that the elderly citizens' income is not as low as was originally anticipated.

What the change in the means test would do would permit the care of the non-service-connected veteran below 65 who does not have the funds to pay for his care.

Chairman **Murkowski**. Have you seen the CBO estimates?

Ms. **Quandt**. Yes, sir.

Chairman **Murkowski**. The CBO estimates say that it will save $360 million in fiscal year 1986. You know, that is something that is tangible and you either agree or disagree or fall in between. It is a little more explicit than I think your answers have been as to whether or not there are specific savings.

Ms. **Quandt**. We have seen the CBO estimates. We have some basic problems with certain assumptions that were made on the number of outpatient visits, that were made on the number of pensioners, and the fact that they may not have been able to track through on our data base the number of zero percent service-connected veterans which should not be considered in the base.

The assumption from the Congressional Budget Office would be that there is no one else in the queue. Our basic premise is that on a base of 11 million veterans, for those, assuming that 16 percent did not meet the means test, could not meet the means test, there are other veterans left in that 8 million difference who will be able to meet the means test. So for us there is no savings on a matter of equity.

Chairman **Murkowski**. I guess the question is are there people out there waiting in line or not?

Mr. **Alvarez**. Yes, sir.

Ms. **Quandt**. There are.

Mr. **Alvarez**. There are, sir.

Chairman **Murkowski**. And your point is that there very difinitely are.

If the Congress modified the means test so that the income and asset ceiling will be increased to, say, $25,000, with no spend-down provision, could this be implemented by, say, October?

Ms. **Quandt**. I did not hear your statement.

Chairman **Murkowski**. If we raised the ceiling to $25,000 from $15,000.

Ms. **Quandt**. Again assuming agreements in the executive branch and the ability to have a facilitated publication of the proposed rate in the Federal Register we could implement it by October 1.

Chairman MURKOWSKI. OK. To conclude my line of questioning before I call on my colleagues your justification is primarily the issue of equity?

Mr. ALVAREZ. Yes, sir.

Chairman MURKOWSKI. Is that right?

Mr. ALVAREZ. Yes, sir.

Chairman MURKOWSKI. As opposed to any savings?

Mr. ALVAREZ. Yes, sir.

Chairman MURKOWSKI. Because it is not going to be cost significant in the sense that your own increased productivity is going to take care of the additional cost. That is what you are saying. So it becomes an equity issue. The issue of equity is the basis for your request for the age 65 provision?

Mr. ALVAREZ. Yes, sir.

Chairman MURKOWSKI. OK, I think that has cleared up something that has been in the minds of the many of us as to just what the questions might be.

Senator Mitchell.

Senator MITCHELL. Thank you, Mr. Chairman.

Mr. Alvarez, can you estimate the expected savings in medical care and construction budget costs if this proposal is adopted?

Mr. ALVAREZ. I think Liz might be able to answer that better. But off-hand, we have not looked at those or tried to get some kind of an estimate on that because, again, this was approached purely from the basis of equity rather than cost savings.

Senator MITCHELL. But on page 5 of your statement, you say, "We project that the proposal would result in a lower rate of growth in VA's medical care and construction budgets than otherwise would be needed."

Ms. QUANDT. Senator Mitchell, that savings and lower rate of growth would come two ways. The very fact that you administer a means test has a dampening effect. There are many veterans that simply would assume "I could probably not pass the means test, so I will not apply." The real——

Senator MITCHELL. Well, I am not asking you, Ms. Quandt, how you arrive at the savings, I am asking you what amount of savings you project?

Ms. QUANDT. That I know of, we have no specific savings. That is an assumption that because it is going to the equity issue that the number of 65-year-olds who would have had blanket authorization, and with the aging veterans, that we would have had a vast, let's say, balloon in people who would have had a carte blanche eligibility. That would then be changed because of the means test, which will diminish that demand.

Senator MITCHELL. So the statement by Mr. Alvarez projecting lower rate of growth in the medical care and construction budgets has no substantive basis to it?

Ms. QUANDT. It is not a statement that we have assigned dollar figures to——

Senator MITCHELL. Right.

Ms. QUANDT [continuing]. At this point.

Senator MITCHELL. All right. Now, did you attempt to estimate what number of veterans over the next 3 years will turn to Medicare to cover some part of their costs if this proposal is enacted?

Ms. QUANDT. If the original proposal before you were enacted, approximately 46,000 veterans over 65 would be subject to the means test. We then believe——

Senator MITCHELL. How many?

Ms. QUANDT. Forty-six thousand would become subject to the means test, would have an income over the $15,000. They might then turn to Medicare for coverage.

Senator MITCHELL. Forty-six thousand out of what total?

Ms. QUANDT. I believe there are more than 2 million veterans who are over 65. But I would like to supply that fact for the record.

Senator MITCHELL. I think it is 3 million, and it is going to be 6 million by 1990, and 9 million by the year 2000.

Now, let me go into that, because it says here on page 4 of Mr. Alvarez' statement,

> Regulations—would establish the circumstances under which a veteran, whose income and asset value exceed the proposed twice-pension-rate standard.

As I read that I understand that to be the aggregate of one's income and assets.

Ms. QUANDT. That is correct.

Senator MITCHELL. And it would be $15,000?

Ms. QUANDT. Yes, sir.

Senator MITCHELL. But are you saying that out of 3 million veterans over 65, only 46,000 own their own homes? Because, obviously, anybody who owned a home would be excluded, would they not, unless you exempt that somehow.

Ms. QUANDT. The home is exempt.

Senator MITCHELL. The home is exempt.

Ms. QUANDT. Yes.

Senator MITCHELL. What other assets are exempted?

Ms. QUANDT. His daily necessities such as the car, his personal belongings.

Senator MITCHELL. How did you arrive at the figure of 46,000?

Ms. QUANDT. The Veterans' Administration in doing its estimate had access to some data from the General Accounting Office. And we used that data because it was based on actual users of the system, namely, fiscal year 1981. We used those income figures and then related that back to what the pension program and the pension requirements for definition of income as the debts and net worth are.

Senator MITCHELL. Can you tell me what the date of that GAO report is?

Ms. QUANDT. That report I believe was recently submitted to us informally on May 3.

Senator MITCHELL. Of this year?

Ms. QUANDT. Yes.

Senator MITCHELL. Would you provide to me and to the committee, all committee members, a detailed statement of the precise method by which you arrived at the estimate of 46,000? I must say, it sounds very low to me. But we would like to look at it so we can attempt to assess that.

[Subsequently, the Veterans' Administration submitted the following information:]

In estimating the probable effects of the means test, the VA utilized demographic and statistical data from its files and income data supplied from a General Accounting Office Study of 1981 VA Patient Treatment File information and 1981 Internal Revenue Service income data. (A copy of the GAO report was sent to the Senate Veterans' Affairs Committee in May of 1985). The results of this analysis indicated that 186,554 current individual users would lose their eligibility for health care at VA expense. Of that number, 46,021 would be over 65. Assuming that 90 percent of those veterans would be eligible for Medicare leads to an estimated 41,419 who would be eligible for Medicare.

Senator MITCHELL. Have you made any effort to estimate what the increased cost to the Government would be of those 46,000, or whatever number of veterans, turning to Medicare?

Ms. QUANDT. Assuming that all those veterans have Medicare it is my assumption from some of our data that our cost of care is less than what the average charges are that Medicare pays to the private sector. There could be an increase of approximately $100 per year for hospital care per person.

There is essentially, in multibillions, a negligible increase to Medicare.

Senator MITCHELL. And how did you arrive at the figure of $100?

Ms. QUANDT. That was arrived at by reviewing some testimony submitted to the House Veterans' Affairs Committee by HCFA [The Health Care Financing Administration, HHS] and then going through our own 1984 cost data from our resource allocation system.

Senator MITCHELL. I would like to have a written statement on that, too. That seems extraordinary. That is less than 1 day per year in the hospital for each of these veterans who are, by definition, the very poorest and therefore the least likely to have received adequate health care prior to that. And you are estimating that all of those veterans going on Medicare would have total hospitalization expenses averaging less than 1 day per year?

[Subsequently, the Veterans' Administration submitted the following information:]

The Veterans' Administration has not yet been able to get adequate data to compare full costs of Medicare payments, including parts A and B, in order to make such a comparative study with Medicare. Such data will soon be available. A study of comparative costs using 1982 reimbursement data from the State of Maryland shows VA costs to be comparable to those of Maryland when adjusted by DRG's for casemix. According to the Health Care Financing Administration (HCFA), the average reimbursement per person served by the Medicare program in 1984 was $5,174 for inpatient hospital services and $710 for physician services—a total of $5,884. Including the one-day deductible of $356, this would make the average Medicare case $6,240. The VA estimates its costs per person hospitalized at $6,003 for 1984, including physician costs. The Medicare cost of $5,884 covers inpatient hospitalization and supplementary medical insurance (Medicare parts A and B), which includes physician and other medical services. The VA cost estimate of $6,003 is an all inclusive figure that covers inpatient and outpatient care as well as physician costs. It also includes an additional 9 percent of VA per-person cost for "debt financing" so as to make VA costs more comparable to those of the private sector, which has to pay the cost of borrowing money.

Dr. GRONVALL. I believe the figure that Ms. Quandt gave was our estimate of the difference of the cost to the Federal Government of providing the care in the VA as compared to providing the care through the Medicare Program and HCFA.

Senator MITCHELL. Oh, all right. Then I misunderstood that.

Dr. GRONVALL. It was not a total cost to Medicare. It was a difference between the VA and the Medicare Program.

Mr. ALVAREZ. That is correct.

Dr. GRONVALL. You may want to clarify that.

Senator MITCHELL. The increase, you estimate it would increase to the Government?

Ms. QUANDT. Yes, because I——

Senator MITCHELL. The difference to the Government?

Ms. QUANDT [continuing]. I am saying that it is $100 less per the case for us to care for the veteran.

Senator MITCHELL. All right. So you have no estimate of savings and you do have an estimate of increased cost to the Government. So it is fair for one to conclude from the testimony here today that this proposal will increase overall costs to the Federal Government for health care, based on what you have just told us? Does anybody disagree? You are here saying this is an equity issue, it is not a cost savings issue.

Mr. ALVAREZ. That is correct, sir.

Senator MITCHELL. And so I am just trying to find out. So we may conclude based upon the testimony you have given here today that if this proposal is implemented total costs to the Federal Government will rise for such health care?

Mr. ALVAREZ. We felt, well, in that context it would rise. But we also feel that that is a, given the total impact, it is a negligible impact.

Senator MITCHELL. I understand that. I understand that. But so that we may make a determination on what we are doing.

Mr. ALVAREZ. Sure. And again, I would like to point out that there are, as we see, cost avoidances in the outyears in terms of the decreased demand in the outyears and in decreased rate of growth of our facility construction and what have you. So in essence, you know, I am talking very broadly here, but I think that we are looking at these things that result directly from the fairness issue, which is our primary concern right now.

Senator MITCHELL. Yes. Well, I understand that. But at the same time, in the outyears as the number of veterans over 65 triples before the end of this century the increase based on their transfer from the VA health-care system to the Medicare system will rise as well?

Mr. ALVAREZ. That is right.

Senator MITCHELL. And that is the only figure you are able to give us? I mean in terms of estimating savings and costs? What you have said is you cannot estimate the savings? You think there will be some. You cannot estimate the increased costs, and you have given us that figure here. So what——

Chairman MURKOWSKI. Senator Mitchell, you are going to have a chance to address questions to the witnesses from CBO, who have indicated that they have a different conception of what the cost savings would be. I would ask that you wind up your questions at this time. I have not put a time limit on, but we have a lot of witnesses to hear from and I am going to have to ask you to complete your questions, at least on this particular subject.

Senator MITCHELL. All right then, Mr. Chairman. Thank you.

Chairman MURKOWSKI. Senator Cranston.

Senator MITCHELL. Mr. Chairman, I have a number of other questions. I will submit them in writing for the record.

Chairman MURKOWSKI. Thank you.

Senator CRANSTON. Mr. Chairman, I would like to say that I respect the 10-minute rule; I think that is very appropriate. But I have questions for the VA that I think will take more than 10 minutes. So I will take 10 minutes now and then subside.

Chairman MURKOWSKI. Thank you.

Senator CRANSTON. But I would like to pursue the matter. OMB insists on checking on or editing written responses to questions, so we do not get the VA's response when we ask them that way directly.

In light of the confusion about the cost implications of the means test I am deeply concerned about the degree to which the VA has been involved in recent negotiations relating to the agency's budget for fiscal year 1986, most particularly in the negotiations between the administration and the Senate Republican leadership that led up to the so-called White House-Senate Republican leadership agreement. In my April 12, 1985, letter to Administrator Walters I requested specific detailed information on the impact of the White House-Republican leadership agreement on the agency's budget submitted to Congress in January.

None of this information was provided in the Administrator's May 7 reply.

I also asked for a detailed description of Administrator Walter's involvement in the decisionmaking processes which led up to the final agreement. Administrator Walters' reply totally ignored that matter.

Mr. Chairman, I ask unanimous consent that a copy of this exchange of correspondence be printed in the record at this point.

Chairman MURKOWSKI. Without objection.

[The April 12, 1985, letter to Administrator Walters and his May 7, 1985, response thereto, referred to above, follow:]

FRANK H. MURKOWSKI, ALASKA, CHAIRMAN

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STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

April 12, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

I am writing in connection with the agreement reached last Thursday, April 4, between the President and the Senate Republican Leadership on the budget for FY 1985 through FY 1988.

Enclosed are excerpts from an April 5 memorandum prepared by the Senate Budget Committee Staff Director summarizing the major provisions of the agreement. As you can see, the memorandum provides very little information on the Veterans' Administration budget. Based on past practice, I do not expect the Budget Committee to provide any further detail, other than appropriations account totals, regarding the VA budget revisions under the agreement and their impact on VA programs.

In the absence of the VA providing more detailed information, I am concerned that the Senate may proceed to consideration of this budget agreement without benefit of specific information regarding its impact on such matters as caseloads under the affected programs, staffing levels, and various other programmatic effects. Therefore, in order to enable the Senate and the Congress to evaluate the budget agreement into which the President has entered, I request that you prepare the changes to the VA documents submitted in February of this year in connection with the President's FY 86 budget submission that are necessary to show in detail the effects of the agreement on VA programs.

In light of the fact that the full Senate may begin consideration of the first concurrent resolution on the budget for FY 86 (S. Con. Res. 32) during the week of April 22, I urge that you develop this information as quickly as possible. Also, in the interest of expediting submission of the changes, I suggest that you provide them in the form of either revised pages with changes made by hand, wherever that would be practical, or as replacement pages.

In addition, I note that the Presidential agreement will directly affect VA budget authority and outlay levels in FY's 87 and 88, as well as FY 86 -- both through overall caps on domestic spending in each of FY's 86, 87, and 88 and reconciliation instructions designed specifically to require the Veterans' Affairs Committees to report legislation that would produce certain budget levels for the VA in each of those years. Therefore, I also request that you provide detailed information with respect to the VA budgets for FY's 87 and 88 under the agreement and the programmatic effects -- at least in terms of the various caseloads and staffing levels involved.

Please also let me know what effect any overall agreement to reduce the federal workforce through this new budget proposal has on VA staffing levels for FY's 86, 87, and 88.

I look forward to your response to this request and ask that, no later than April 18, you provide me with whatever information is available at that point and a timetable for providing the remainder.

Finally, as you know, I have longstanding concerns regarding the ability of the individual serving as Administrator to participate in and influence budget decisions within the Executive Branch that affect the VA. During your confirmation hearing in December 1982, in response to a question I asked you in this regard, you stated, "I intend to run the Veterans' Administration, and I intend to represent our budget to OMB. It is not going to be the other way around." Also, responding to my question as to whether you could provide assurance that you would be consulted before any Administration revisions are made in the VA budget, you indicated that you could not give such assurances but that being consulted or heard in that regard would "be of high priority" to you. Since the VA's budget has been very significantly revised in the agreement into which the President entered, I ask that you include in your initial response to this letter a description of your involvement in the decision-making processes, insofar as VA programs are concerned, leading up to both the formulation of the Administration's position in the negotiations with the Senate Republican Leadership and the final agreement.

As always, I greatly appreciate your cooperation and assistance with regard to matters of concern to our Nation's veterans and their families.

With warm personal regards,

Cordially,

Alan

Alan Cranston
Ranking Minority Member

Enclosure

[illegible]
RUDY BOSCHWITZ, MINN
ORRIN G. HATCH, UTAH
JOHN TOWER, TEX
MARK ANDREWS, N DAK
STEVEN D. SYMMS, IDAHO
CHARLES GRASSLEY, IOWA
ROBERT W. KASTEN, WIS
DAN QUAYLE, IND
SLADE GORTON, WASH

[illegible]
JOSEPH R. BIDEN, JR., DEL
J. BENNETT JOHNSTON, LA
JIM SASSER, TENN
GARY HART, COLO
HOWARD M. METZENBAUM, OHIO
DONALD W. RIEGLE, JR., MICH
DANIEL PATRICK MOYNIHAN, N Y
J. JAMES EXON, NEBR

STEPHEN BELL, STAFF DIRECTOR
RICHARD N. BRANDON, MINORITY STAFF DIRECTOR

United States Senate
COMMITTEE ON THE BUDGET
WASHINGTON, D.C. 20510

TO: REPUBLICAN SENATORS AND LEGISLATIVE DIRECTORS

FR: STEVE BELL, STAFF DIRECTOR

RE: SENATE-WHITE HOUSE DEFICIT REDUCTION AGREEMENT

DATE: APRIL 5, 1985

Attached is a brief summary of the major provisions of the deficit-reduction agreement reached Thursday evening between the Senate Republican Leadership and the President.

PLEASE NOTE: ALL NUMBERS ARE SUBJECT TO CHANGE DURING THE NEXT WEEK. AGGREGATES (DEFICIT NUMBERS, OUTLAYS, REVENUES, ETC.) HOWEVER, WILL PROBABLY CHANGE VERY LITTLE.

SUMMARY

1. Real growth in defense will be 3 percent for Fiscal Years 1986, 1987, and 1988 (up from the Senate Budget Committee's reported resolution real growth rates of zero percent in Fiscal Year 1986, and 3 percent in both Fiscal Years 1987 and 1988);

2. Social Security recipients would get an automatic 2 percent Cost-of-Living-Adjustment (COLA) in all three Fiscal Years, instead of the one-year freeze recommended by the Senate Budget Committee;

3. Domestic spending cuts are slightly larger than in the Budget Committee recommendation.

4. No new taxes are recommended.

4-4-85

DRAFT

SUMMARY OF SENATE-WHITE HOUSE AGREEMENT

($ billions)

	FY 1985	FY 1986	FY 1987	FY 1988
Outlays:				
050: National Defense	252.0	276.1	298.4	321.4
150: International Affairs	18.0	17.9	16.9	16.5
250: General Science, Space, and Technology	8.7	8.7	8.8	9.0
270: Energy	6.5	5.1	4.7	3.9
300: Natural Resources and Environment	13.1	12.4	12.2	12.3
350: Agriculture	21.0	14.6	14.7	13.1
370: Commerce and Housing Credit	5.6	2.1	0.2	2.3
400: Transportation	26.1	25.6	26.9	26.4
450: Community and Regional Development	8.7	7.6	6.8	6.2
500: Education, Training, Employment, and Social Services	30.3	29.7	28.5	28.8
550: Health	33.5	34.5	35.9	37.2
570: Medical Insurance	65.2	67.7	73.6	81.7

4-4-85 P.M.

SUMMARY OF SENATE-WHITE HOUSE AGREEMENT (CONTINUED)

($ billions)

	FY 1985	FY 1986	FY 1987	FY 1988
Outlays:				
600: Income Security	128.6	118.1	122.2	126.2
650: Social Security	189.3	197.8	206.5	216.1
700: Veterans Benefits and Services	26.3	26.1	26.2	26.4
750: Administration of Justice	6.4	6.7	6.9	7.0
800: General Government	5.8	5.3	5.2	5.4
850: General Purpose Fiscal Assistance	6.4	6.5	3.1	2.1
900: Net Interest	129.7	142.6	152.1	153.7
920: Allowances	0.3	-1.1	-0.6	0.4
950: Undistributed Offsetting Receipts	-32.4	-35.0	-37.8	-41.1
Total outlays	949.1	969.0	1011.4	1055.0
Revenues	736.2	793.8	866.6	956.2
Deficit	212.9	175.2	144.8	98.8

4-4-85 P.M.

COMPONENTS OF SENATE-WHITE HOUSE AGREEMENT

($ billions)

	FY 1985	FY 1986	FY 1987	FY 1988
Baseline deficit....................................	213.3	227.4	244.7	243.6
Revenue increases..................................	---	-1.1	-2.3	-3.7
Outlay reductions:				
Policy changes................................	-0.4	-48.6	-87.9	-121.9
Debt service savings..........................	---	-2.5	-9.7	-19.2
Total deficit reductions............................	-0.4	-52.2	-99.9	-144.8
Deficit in Senate-White House agreement.................	212.9	175.2	144.8	98.8

SUMMARY OF MAJOR PROPOSALS IN SENATE-WHITE HOUSE AGREEMENT

Function 700: VETERANS BENEFITS AND SERVICES

	Change from baseline (Outlays-$ billions)			
	FY 1985	FY 1986	FY 1987	FY 1988
2 percent Compensation and Pension COLA	---	-0.2	-0.5	-0.8
Increase VA housing loan origination fee	---	-0.4	-0.4	-0.3
Reform VA hospital and medical care	---	-0.4	-0.7	-0.8
Total change from baseline	---	-1.0	-1.6	-2.0

SUMMARY OF MAJOR PROPOSALS IN SENATE-WHITE HOUSE AGREEMENT

Function 700: Veterans Benefits and Services (continued)

- Allow 2 percent cost-of-living adjustment for compensation and pension programs. The Senate-White House agreement proposes a 2 percent COLA for the veterans income security programs in FY 1986, FY 1987, and FY 1988. This adjustment is consistent with the recommended increase for social security and other federal pension plans.

- Increase VA housing loan origination fee. The agreement recommends increasing the VA housing loan origination fee from one to 3.8 percent. The proposed fee corresponds to the current premium for FHA mortgage insurance. The fee collections will be deposited into the VA Loan Guaranty Revolving Fund and will contribute to the fund's solvency.

- Reform VA hospital and medical care. The agreement proposes two major reforms to VA hospital and medical care:

  --Reform of VA health care eligibility through the implementation of a means test for non-service-connected veterans regardless of age; and

  --Allow the VA to recover the cost of non-service-connected care provided to privately insured veterans.

  These reforms will contibute to deficit reduction by curbing the VA's history of inflationary spending for medical services. Finally, these reforms will allow the VA to direct scarce resources to caring for the service-connected-disabled veteran.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

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Honorable Alan Cranston
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

Your letter of April 12, 1985 requested specific details on VA programs impacted by the budget agreement reached on April 4, between the President and the Senate Republican Leadership. We have received essentially the same information you have except we also have some information on a budget authority basis. Any analysis prepared is complicated by the fact that the Budget Committee is working from a baseline which is different from the President's Budget.

With respect to budget authority, information received indicates that the amount included for VA programs is $26.7 billion which is $400 million below the President's Budget request. A significant portion of this reduction represents the reduction in cost-of-living allowances in Compensation and Pensions from 4.1% to 2.0%.

The reduction to a 2.0% COLA is consistent with the Committee's proposal to hold the Social Security cost-of-living increase to 2.0%. I support this proposal. As I have always stated, I fully support budget deficit reduction initiatives so long as they are applied consistently and veterans do not take a disproportionate share of the reductions.

The agreement actually reduced the VA housing loan origination fee from the President's Budget level of 5.[illegible]% to 3.8%. Also additional receipts are anticipated from the collection of third party reimbursements for non-service-connected care to privately insured veterans. The change in the loan fee should have no impact on budget authority.

With respect to FY 1987 and FY 1988, no attempt is being made to bridge changes from the President's Budget estimate. As you know I testified during the budget hearings that the outyear base totals were plugged numbers. Therefore, any comparison from that base would be meaningless. The FY 1987 and FY 1988 base totals shown in the FY 1986 President's Budget will be renegotiated when the FY 1987 budget process begins with OMB.

Thank you for your continued interest in the budget activities for the Veterans Administration. Please be assured that I will continue to monitor the FY 1986 budget process to ensure that our nation's veterans receive the funding support they so richly deserve.

Sincerely,

Harry N. Walters

HARRY N. WALTERS
Administrator

Senator **Cranston**. Mr. Alvarez, I can only assume from Mr. Walters' unwillingness to address the question of his involvement in the President's decision to revise the VA budget that he had no involvement, exactly the situation that prevailed for former Administrator Nimmo on two occasions with respect to the fiscal 1982 and 1983 budgets. Am I correct in drawing this inference? Or can you enlighten the committee on the Administrator's role in that decisionmaking process?

Mr. **Alvarez**. Senator, I think in fairness to Mr. Walters' response, at the time we were still trying to resolve, as we are still, the differences and a lot of these estimates that came out as a result of the Senate-White House conference and agreement. And——

Senator **Cranston**. Well, I am asking, I am asking really what was Mr. Walters' involvement before the President worked out his arrangement or deal with the Republican leadership in the Senate?

Mr. **Alvarez**. Before the arrangement was made with the leadership, sir, our submission was in the package. At that point that was the termination of our involvement in figures that you saw.

Senator **Cranston**. He was not then involved in the President's decision to make revisions?

Mr. **Alvarez**. That is correct.

Senator **Cranston**. Would you provide in writing for the record detailed information responding to each of the questions I asked in my April 12 letter, including the one with respect to his involvement?

Mr. **Alvarez**. Yes, sir.

[Subsequently, the Veterans' Administration submitted the following information:]

The Budget Committee did not provide much specific detail and as indicated in Senator Cranston's April 12 letter this was consistent with past practice. Because the Veterans' Administration lacked the specific detail needed to respond to the letter, the May 7 reply was necessarily vague. The VA could speculate on what the Committee was providing for the VA by appropriation account but is very reluctant to do so as we like to work with supportable facts. When totals are provided without a specific account backup and the VA is requested to provide these unknowns, this leaves the VA open to supplying rumors and not facts. This could lead to a gross distortion or inaccurate description of what the Budget Committee was proposing for veterans programs. However, we now have more specific information as to what the Appropriations Committees will be providing. It is more important to concentrate our efforts on what is actually being provided. The April markup has been overtaken by Appropriations Committee action.

Regarding the Administrator's role in the decisionmaking processes which led up to the final White House-Senate Republican leadership agreement, as we indicated the Administrator was not involved in the President's decision to make revisions.

Senator CRANSTON. Your testimony on the means test states that enactment of the agency's proposed legislation would "result in a lower rate of growth in VA's medical care and construction budgets than otherwise would be needed."

In view of your response to Senator Murkowski that there will be no cost savings from the means test, how do you reconcile that position with the assumption underlying the administration's Senate Republican leadership budget package, which the full Senate accepted with respect to VA medical accounts, that implementation of a means test will reduce VA medical care appropriation needs by approximately $400 million in the first year?

Mr. ALVAREZ. Senator, I think I missed the last, just the last part of that question. But with respect to the decrease——

Senator CRANSTON. Well, you indicated to Senator Murkowski there would be no savings. How does that equate to the assumption underlying the budget package worked out by the leadership of the Republican side and the White House, which the Senate accepted, that implementation of a means test would reduce the medical care appropriation needs by $400 million? How do you reconcile those two seemingly unreconcilable positions?

Mr. ALVAREZ. Well, right offhand, sir, I think we have been trying to reconcile that all along since we got those figures. Our position was that, which refers to the decreased rate of growth, refers to the decreased demand that we will see in the outyears.

We are—we still, however, feel that there are not any cost savings, foreseeable cost savings at this point because of the increasing demand on the services of the VA. What we are looking at in terms is basically some cost avoidances. But as far as the—and Midge can back me up on this—as far as the $400 million figure that came out, that is one that we are still trying to resolve ourselves.

Ms. QUANDT. That is correct.

Senator CRANSTON. Well, at this point then you cannot reconcile those two positions, it appears?

Mr. ALVAREZ. That's right.

Senator CRANSTON. Specifically, if the appropriations were cut by $400 million, what would the impact be on medical care account FTEE's and on VA inpatient episodes of care and outpatient visits?

Mr. ALVAREZ. Can you address that, Midge?

Ms. QUANDT. I can address approximately the change in episodes of care and outpatient visits. I cannot offhand, without stating it for the record, address the FTEE cuts. But there we would lose more than 2 million outpatient visits. And we would lose—I have to find it. I have it.

Mr. ALVAREZ. We would like to have a chance to submit that for the record if we may, in addition.

[Subsequently, the Veterans' Administration submitted the following information:]

It is our estimate that a $400 million reduction in medical care funding, taken in balance, would result in a staff reduction of approximately 9,890 FTEE.

Senator CRANSTON. Well, Dr. Gronvall must understand the staffing figures because you have had a lot of time to be considering this.

Dr. GRONVALL. I have been sitting here trying to recollect. We have done those calculations. It is a relatively easy matter, given a reduction in the medical care appropriations to translate that into staffing reductions and then into workload reductions in terms of the fewer number of patients that would be treated both in our hospitals and clinics.

I am sorry, but I do not remember a figure that I would be comfortable using. But that is a figure that is easy to calculate for a given reduction of the medical care appropriations.

Senator CRANSTON. Well, Ms. Quandt, you were about to give me one other answer, I believe?

Ms. QUANDT. It would be a cut of at least 2 million outpatient visits and approximately 80,000 inpatient episodes of care.

Senator CRANSTON. That is a cut from what was proposed in your January budget, as I understand it?

Ms. QUANDT. Yes.

Senator CRANSTON. Yes.

You have some backup people with you. Do any of them have the answers to these questions? Or could they give them to us before the hearing is over? Then we will hope to get those answers before the hearing is over today.

With further reference to your statement that the means test "would result in a lower rate of growth in VA's medical care and construction budgets than would otherwise be needed," please provide--and this is for the record—a table showing the projected rate of growth in each of those budgets from fiscal 1986 through fiscal 1995 with and without a means test being enacted.

[Subsequently, the Veterans' Administration submitted the following information:]

The testimony regarding growth was meant to convey the notion that the demand for services in the VA medical care system is sensitive to the size of the pool of potential users of that system. If the pool of potential users is reduced, so too is the rate of growth necessary to match demand. Savings, then, are illusory as there still will be growth. Lower growth does, however, reduce the need for as much construction, personnel, contract care, etc., but the degree to which that is true is not specifically known.

Senator CRANSTON. Given your position about no cost savings from the means test, would it be acceptable if the legislation were amended to make imposition of a means test expressly contingent on there being appropriated to the VA for medical care for fiscal 1986 at least the amount requested in the President's January budget, which was $9.1 billion?

Mr. ALVAREZ. Yes, I think. I believe the answer is yes to that.

Senator CRANSTON. Since your testimony provides very few details on how a means test would actually be implemented I have a lot of questions in that regard. First, how do you intend to verify a veteran's statements regarding income and assets?

Chairman MURKOWSKI. I think that question was already answered and it is in the record.

Senator CRANSTON. I was talking about verification, which I do not think we got into.

Ms. Quandt. Verification procedures are still under discussion. And we realize that we will have to verify the income data.

Senator Cranston. Would something be done to verify each veteran's statement? Would it be deemed necessary to check up on the accuracy of each veteran's statement?

Ms. Quandt. My inclination would be to say it would be wiser from an administrative viewpoint to sample that.

Senator Cranston. To do what?

Ms. Quandt. To sample. And I would prefer to, again if we are going to use the pension-like form, try to follow whatever procedures have been established in our codepartment in DVB in order to follow through on this.

Senator Cranston. What is done to verify pensioners' income?

Ms. Quandt. I cannot answer you.

Senator Cranston. Can anybody answer that?

Mr. Alvarez. We do not have anybody from the Department of Veterans' Benefits here.

Senator Cranston. Supply it for the record?

Mr. Alvarez. Yes, sir.

Senator Cranston. What options do you believe there would be, Ms. Quandt, what, for verification? What kind of sampling?

Ms. Quandt. I would, I would prefer if possible, if it is required, that we determine a suitable sample of our patient population who must provide to us the information that they have spent down or what their income is, and then to utilize various other records which are available. Those records could come out of the DVB claims file.

Senator Cranston. I am really not asking what would be required. What would be your intention, Mr. Alvarez, what would be the intention of the VA in regard to verification?

Mr. Alvarez. I do not think I can answer that right now, Senator, because——

Senator Cranston. Could you give us within a week a written response?

Mr. Alvarez. Yes, sir.

Senator Cranston. Another example. If a veteran seeks care in a VA health-care facility and indicates that he or she has income and assets above twice the pension level, will VA policy be to deny an initial examination to that veteran?

Ms. Quandt. Our plan is that we will not make a change in how we operate the hospitals because of the means test. So that if a veteran comes to us seeking care he will be examined to determine whether or not he requires medical care. At that point in time we will interview the veteran for his assets, income, his net worth. And if after that it is determined that he cannot meet the means test he will be billed for that examination.

Senator Cranston. All veterans would then be examined before eligibility——

Ms. Quandt. Yes.

Senator Cranston [continuing]. Is determined?

Ms. Quandt. Yes.

Senator Cranston. I have used 10 minutes. And I, Jay, I would be glad to yield to you now and then I want to have another opportunity.

Senator **Rockefeller**. Senator Cranston, you have already addressed a number of questions I want to ask. You are on a line of questioning which I think is important. If it is permissible with the chairman I would like to yield my time to you, sir.

Senator **Cranston** [presiding]. I thank you. And in the absence of the chairman I will take advantage of it.

Do you intend to require a veteran to provide income and asset information each time he or she seeks care for a different disability and to verify that information each time?

Ms. **Quandt**. We would propose that we seek this information the first time a veteran applies during a given fiscal year and use that data for the remainder of the year.

Senator **Cranston**. Would that be acceptable to OMB in your opinion?

Ms. **Quandt**. I hope it will.

Senator **Cranston**. Mr. Alvarez, what do you think about OMB? Do you think they would accept that?

Mr. **Alvarez**. I think that they would accept that. Yes, sir.

Senator **Cranston**. Another example of the situation. How will the VA handle an applicant who is too sick to give reliable answers to questions about income and assets or a veteran who does not have the information needed to complete the answers and who lives a significant distance from the facility?

Dr. **Gronvall**. Senator Cranston, our clear intent would be to meet the medical needs of any veteran who comes to us for care. In any situation where the veteran is ill and needs immediate care we will provide that care independent of any question about financial ability to pay. If a veteran cannot give that information for whatever reason, again, we would provide the care and then attempt to work out the administrative details subsequently of getting the information about financial ability to pay.

But we have taken a very clear position that medical need will be met immediately, independent of the financial screening.

Senator **Cranston**. In effect are you saying that if a veteran needs care that would be a medical emergency?

Dr. **Gronvall**. Yes.

Senator **Cranston**. Would the same thing apply if a veteran with income over twice the pension level lives a long way from the hospital and comes without evidence of having made the expected medical expense contribution? Would you proceed to give him care?

Dr. **Gronvall**. I think the primary judgment that would be made would be the medical judgment of whether the person needed care immediately. And if that medical judgment is made, care will be provided.

Senator **Cranston**. You are adopting a stance that would not fit the normal definition of a medical emergency. But you would provide care then if the veteran appears to need it?

Dr. **Gronvall**. Perhaps I should expand on that. If a veteran were judged medically to need care but the situation was such that the need for care would not be compromised by completing the financial analysis and then referring the veteran, in the case that he did have financial means to purchase care, to another community facility to obtain that care. That is, that is the action that would be taken.

My response was that if medical care was needed immediately and it was not feasible, for whatever reasons, to refer the veteran elsewhere, the care would be delivered. In that sense I am using a definition of need for emergency care.

Senator **CRANSTON**. The draft legislation makes reference to an annual spend down for veterans who are not initially eligible on the basis of their income and assets. Does that suggest that a veteran who has met the spend-down requirement and is receiving care in the VA during a particular 12-month period will at the end of that period have to leave the VA to seek care outside the VA until he or she again meets the spend-down requirement?

Ms. **QUANDT**. That is true. At the point in time at which the law is passed and implemented those veterans under care will be essentially grandfathered until we come to another fiscal year, at which point if that patient has been discharged from care and then comes back to us he will have to meet the requirements.

Senator **CRANSTON**. That is going to be done each fiscal year then? Is that what you mean by annually?

Ms. **QUANDT**. It would be done each fiscal year provided that the veterans were discharged in a succeeding year.

If you look at proposed hospital care, we do not propose to have a fiscal year break the patient's treatment regimen.

Senator **CRANSTON**. So at the end of the fiscal year a veteran would be required to leave the hospital under those circumstances?

Ms. **QUANDT**. No. What I am saying is if the patient were under treatment, if we implement the bill October 1 and that patient is still under treatment on January 5, we would not say to that patient, "You must leave the hospital and reapply." Only at the point where the patient was discharged and then came back to us would we then say, "You need to fill out your form and apply."

Senator **CRANSTON**. That procedure is not really clear in the legislation that has been submitted. So I presume you would not object to our seeking to make the legislation spell that out clearly?

Ms. **QUANDT**. No.

Senator **CRANSTON**. Dr. Gronvall, in the draft bill submitted there is this definition of an emergency: "For medical services furnished in extraordinary or emergency services," which is different from the situation we are talking about. But you are assuming the position that care would be granted to a veteran if he seemed to need it, even though it would not fit this definition of extraordinary or emergency circumstances?

Dr. **GRONVALL**. I think, Senator Cranston, the part of the bill that you are referring to is in reference to a situation where a veteran would have financial means that exceeded the threshold level, but because of extraordinary circumstances or the extraordinary emergency character of the care, that veteran could be admitted and cared for in the VA in spite of having means to provide care elsewhere.

An example that has been used for such a circumstance—the definition would have to be developed—but the kind of example that has been used is in certain instances of spinal cord injury where very expensive continuing care over a long period of time is provided in the VA to individuals who do have financial means that might exceed the screening level.

The situation I was describing was an individual veteran who appears to need medical care right now and we would deliver that care and then work out the administrative details later.

Senator **Cranston**. The bill does not seem to provide for that sort of procedure. What part of the bill, if any, are you referring to?

Dr. **Gronvall**. I guess I do not know that I am referring to any specific provision that is described in the legislation. What I am describing is perhaps discussions that has occurred within the Veterans' Administration and between the VA and OMB as to how we would actually administer the bill and operate our medical centers in terms of patient care.

We have taken a categorical position that in the case of a medical emergency or someone who needs care we would deliver that care and then work out the income information subsequently.

Senator **Cranston**. Mr. Ivers, in view of the definition of this emergency care in the bill, wouldn't you agree that you would probably have to get a revision to cover the sort of procedure that Dr. Gronvall was outlining?

Mr. **Ivers**. That may very well be, Senator. Although I believe that what Dr. Gronvall is discussing here may be standard medical practice which would not require a specific definition. But that is something that we would work out in regulation, I think, rather than in the legislation itself.

Senator **Cranston**. Well, I think we will have to consider carefully whether the bill will authorize the appropriate procedures that you are outlining and that Dr. Gronvall and Ms. Quandt have testified.

If a veteran applicant for care has not yet met the spend-down requirement, will he be treated or admitted and then pay the rest of the spend down as appropriate to the VA?

Ms. **Quandt**. No.

Dr. **Gronvall**. The intent of this bill would be that if the veteran has not yet met the provision and the veteran's medical condition allows referral, the veteran would be referred to a community facility to continue or receive medical care there and pay for it until the veteran spent down to the eligible level.

Senator **Cranston**. So he would not be treated in the VA under those circumstances?

Dr. **Gronvall**. Correct.

Senator **Cranston**. On the matter of pension validation I note that Herb Mars from the compensation and pension service is here. Can he enlighten us on what is done to validate pension eligibility?

Mr. **Mars**. We have always had a verification program through annual income questionnaires. And this year we have established a new procedure where we will be sending out a one-page document broken down by the various categories of pensioners, obtaining all of the income information. We ask them what their medical expenses are, because under the improved pension program we can offset medical expenses over 5 percent of the total income support level.

We have verification programs through computer matching systems with Social Security, black lung, railroad retirement, and other Federal programs that we do on a regular basis, running our tapes against their tapes to verify the amount of these recorded incomes.

Senator **CRANSTON**. Mr. Alvarez, is that the way you would intend to proceed, roughly?

Mr. **ALVAREZ**. Well, Midge can answer that.

Ms. **QUANDT**. Yes.

Senator **CRANSTON**. I thank you.

Jay, I have completed that line of questioning. While I have other questions, I will yield to you, because I am going onto other questions.

Senator **ROCKEFELLER**. I yield back to the Senator.

Chairman **MURKOWSKI** [presiding]. I would indicate that we have about 20 minutes. So I think the time is yielded.

Senator **ROCKEFELLER**. I have no questions.

Chairman **MURKOWSKI**. Further questions?

Senator **MITCHELL**. I do have additional questions, Mr. Chairman.

Chairman **MURKOWSKI**. All right. We have further witnesses, as you know, so I would appreciate trying to expedite the questioning process. I recognize that those are the realities we have to live under.

Senator **MITCHELL**. I am sorry. I misunderstood you. I thought you said you have 20 more minutes for these witnesses. You mean for the whole hearing?

Chairman **MURKOWSKI**. No, I did not set a time limit. We are limiting our questions to 10 minutes per member. The question of the appropriateness of a second round is where we are at presently. I would appreciate it, since we have other witnesses to accommodate, if we could submit questions to the panel for response in writing whenever possible.

Senator **MITCHELL**. I will be very happy to abide by the chairman's request.

Chairman **MURKOWSKI**. If you have some specific questions, at this time, because we have not gone into the questions covering third-party reimbursement for this panel.

Senator **MITCHELL**. That is what I was going to ask them.

Chairman **MURKOWSKI**. OK. I felt quite sure that we would want to get into that.

On the question of the constitutionality of third-party reimbursement, I understand that the VA and the Justice Department have given opinions that the third-party reimbursement proposal does meet constitutional requirements. Is that correct, Mr. Ivers?

Mr. **IVERS**. That is correct, yes.

Chairman **MURKOWSKI**. So you do not see a difficulty there?

Mr. **IVERS**. No.

Chairman **MURKOWSKI**. I am told that estimated VA recoveries under the third-party reimbursement proposal would include $65 million in fiscal year 1986 and $285 million in fiscal year 1990. That is GAO data. Is that the position of the VA?

Dr. **GRONVALL**. Correct.

Ms. **QUANDT**. Mr. Chairman, that estimate is based upon our own estimate of the number of veterans who come to us who then indicate that they have health insurance. And our formula is to how much of our care would be covered and what we would recoup on the dollar.

Chairman **Murkowski**. It is my understanding that you do not have specifics on the VA administrative costs? Is that correct or incorrect?

Mr. **Alvarez**. No, we have a set of specifics.

Chairman **Murkowski**. Good. We would like to hear your specifics. What are the costs?

Ms. **Quandt**. Our costs, administrative costs for fiscal year 1986 would be $2.2 million or 111 FTEE. Extending up to fiscal year 1990, $3.64 million and 160.5 FTEE. That is based on the assumption we will be billing for inpatient only and phasing in outpatients.

Chairman **Murkowski**. So when we look at VA recoveries and VA costs, the difference is the net, is that correct?

Ms. **Quandt**. That is correct.

Chairman **Murkowski**. So there is a savings of some $62 million in fiscal year 1986, and as to 1990, why, take your chances. But it is substantial you feel?

Mr. **Alvarez**. Yes, sir.

Chairman **Murkowski**. Like in excess of $250 million?

Ms. **Quandt**. We believe our estimate is an extremely conservative estimate.

Chairman **Murkowski**. Thank you. What is the cost to the insurer? None, I assume.

Ms. **Quandt**. We will not—there will be none.

Chairman **Murkowski**. What is the impact? Does it allow the Federal Government to recover the reasonable value of medical services provided to insured veterans with no service-connected disabilities?

Ms. **Quandt**. In our opinion it would.

Chairman **Murkowski**. The proposal, basically, is going to place the Government in the same position by reimbursement as the private health-care providers then? Is that not correct?

Ms. **Quandt**. That is correct.

Chairman **Murkowski**. Have you had discussions recently with various health-care organizations on this question?

Ms. **Quandt**. Not specifically on this question. We had a meeting with the——

Chairman **Murkowski**. Well, I am talking about third-party reimbursements.

Ms. **Quandt**. That is what I am referring to, too——

Chairman **Murkowski**. OK, good.

Ms. **Quandt** [continuing]. Mr. Chairman. Approximately 6 to 8 months ago we had a conversation with representatives of the health insurance industry on whether or not there was third-party payments anticipated, on what some of our practices were as far as our length of stay, on our PRO reviews. We have had none specifically with what we would call third-party payers in the last 4 months.

Chairman **Murkowski**. It is my understanding that Blue Cross and others in testimony before the committee have objected to third-party reimbursements on the grounds that it violates the most basic principle of insurance contracts and it violates the protection of the fifth amendment relating to just compensation for private property taken for public use.

Yet, you have indicated that it is your understanding that the VA and Justice Department opinions address the issue of constitutionality. In the case of a veteran who is employed by a firm that offers health and accident insurance, where money is withheld from his earnings and a premium contribution is made by the employer which is tax deductible, yet the insurance benefits are not drawn on by the veteran simply because the veteran goes to the VA hospital. Under the current procedure, isn't that kind of a benefit that the insurance companies enjoy in the sense of a windfall?

Mr. IVERS. That is precisely one of the issues that third-party reimbursement addresses, Senator, that in effect veterans who are in that situation to some small degree subsidize the insurance carriers.

Chairman MURKOWSKI. Because the veteran, I assume, has no choice in his employment. He works for Acme Construction and they withhold and the employer gets the deductibility and the veteran gets no benefit.

Mr. IVERS. He may or may not have a choice. However, the fact that he carries the medical coverage and then does not take advantage of those benefits because he is a veteran and goes to a VA facility, the premiums are paid nonetheless.

Chairman MURKOWSKI. Do you have any position from the standpoint of recognizing what validity the insurance underwriters have in these cases where they seem to be enjoying a windfall and they are objecting to the right to have a veteran utilize his coverage in a VA medical facility?

Mr. IVERS. Both the VA and the Justice Department have considered that fairly thoroughly and carefully, and we are unable to find any support at all, legally.

Chairman MURKOWSKI. I think my time is up.

Senator Cranston.

Senator CRANSTON. I would like to get your reaction to an alternative to your proposal to make veterans age 65 and older subject to a means test. Let us assume that the Congress enacted legislation establishing a statutory priority for inpatient and outpatient care listing all categories of veterans eligible for VA care with veterans who are unable to defray the cost of the needed care given priority over veterans age 65 and older who do not meet that test. Wouldn't that address your concerns about the fairness of the current system without taking away anybody's eligibility?

Mr. ALVAREZ. Mr. Chairman, I think that is a very comprehensive proposed alternative there. And I do not think we fully grasp everything involved in that. Could we perhaps give you a little——

Senator CRANSTON. Well, would you think that over and submit a response in writing to that?

Mr. ALVAREZ. I would be pleased to do that, sir.

[Subsequently, the Veterans' Administration submitted the following information:]

Rearranging priorities would not address the focused issue of equity. The equitable issue is one involving the same treatment of non-service-connected veterans based upon financial status and medical need. The rearrangement of priorities based in part upon that same discriminator, age, does not address our concern over disparate treatment of veterans hinging on the age variable.

Senator **Cranston**. I would like to ask how you would deal with veterans who have incurred medical costs less than their "expected medical expense contribution" and who are faced with expenses for inpatient examinations, possible surgery and followup care that are expected to be substantial but cannot at the time of examination be estimated with any accuracy, possibly until surgery is begun. An example would be a case in which the veteran might have cancer, but whether he or she does or does not or how widespread it is won't be known until surgery is performed. In such cases, assuming the veteran has one dependent, has income of $22,000, and has incurred medical costs equal to 25 percent of the expected contribution, and the best estimate possible is that the care needed will cost anywhere from an amount somewhat less than the expected contribution to as much as $100,000 more than the expected contribution, I have the following questions under that set of circumstances:

Would the VA deny the care? Or would it provide the care? And if it does provide the care, would it bill the veteran for the costs of care up to the point at which the veteran would have made the full expected contribution?

Ms. **Quandt**. Senator Cranston, you are now at this point tying together the means test and third party together? Or only the means test?

Senator **Cranston**. No; just trying to get at the means test.

Ms. **Quandt**. If this were a patient who came to us and was examined and it was determined that the patient did not have what might be called catastrophic illness, that patient who had not spent down to his medical contribution would routinely be referred to the private sector until the patient did spend down.

If the patient were determined or viewed in the eyes of a physician or anyone else to have what is considered a catastrophic illness, and let's say cancer is largely, the agency, through the proposed regulation, would have the right in certain cases to waive that spend down and accept the patient for care. If the patient has health insurance it would be proposed to collect that balance, the difference, from the health insurance company.

Senator **Cranston**. Mr. Ivers, I would like to ask you, where in your proposed legislation is there an exception for catastrophic illness?

Mr. **Ivers**. I do not believe there is a specific exception for catastrophic illness stated in the legislation.

Senator **Cranston**. Don't we have to cover that then?

Ms. **Quandt**. That would be covered in the regs.

Mr. **Alvarez**. That would be covered in the regs, Doctor.

Ms. **Quandt**. Senator Cranston, that would be covered in the regulation that will be published for public comment.

Senator **Cranston**. I presume you would not have objection to it being specified in the legislation?

Mr. **Ivers**. No.

Senator **Cranston**. The draft legislation provides that waivers of expected contributions would be permitted in exceptional and unusual circumstances and to avoid substantial hardship. The draft measure would also provide that a waiver shall not be granted categorically either for categories of illness, expenses, income, procedures, types of care, or veterans. This prohibition against categorical waivers would seem to preclude the adoption in the implementing regulations of guidelines providing for equitable administration of waivers, so that similarly situated veterans would receive similar treatment. The result would be a purely ad hoc waiver process that could vary enormously from facility to facility and which would raise major equal protection problems.

Do you construe the language of the bill to preclude such clear binding guidelines for the consideration of waiver applications?

Mr. IVERS. No, I do not.

Senator CRANSTON. Would your draft legislation preclude a rule providing for waivers for all catastrophically disabled veterans or for catastrophically expensive medical care needs?

Mr. IVERS. Would it preclude that?

Senator CRANSTON. Yes.

Mr. IVERS. No, it would not, Senator. That is something that could be covered by regulation.

Senator CRANSTON. If, as some contend and data in the past have supported, an episode of care provided through the VA is less expensive than a similar episode provided in the private sector, why would it not be to the Federal Government's advantage to have Medicare-eligible veterans receive needed care in the VA?

Dr. GRONVALL. It seems to me, Senator, that is a question that we cannot fully respond to. I think that requires a deliberation at a higher level than the individual VA agency.

Senator CRANSTON. Thank you.

I would yield for a moment. Senator Specter has a statement for the record.

Senator SPECTER. I thank the distinguished Senator from California.

Mr. Chairman, I commend you for convening this important meeting on the administration's veterans' health-care policy. I ask unanimous consent that my full opening statement be inserted in the record.

Chairman MURKOWSKI. Without objection.

Senator SPECTER. And I also ask unanimous consent, Mr. Chairman, that a series of questions which I have be propounded in writing.

I would like to stay longer, but I am obligated to chair another hearing on the D.C. Subcommittee, which I must go to now.

But I thank Senator Cranston for letting me speak.

Senator CRANSTON. Thank you very much.

Senator SPECTER. Thank you, Mr. Chairman.

[The prepared statement of Hon. Arlen Specter, a U.S. Senator from the State of Pennsylvania, follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I commend you for convening this important hearing regarding the Administration's veterans health care policy legislative proposals.

I welcome and thank our witnesses, Mr. Everett Alvarez, Jr., Nancy M. Gordon, Ph.D., Ms. Mary Nell Lehnhard, Mr. Philip Briggs, and Mr. Richard Fogel for their thoughtful written testimony and for appearing before the Committee today.

Mr. Chairman, securing adequate health care for our Nation's veterans is one of this Committee's greatest challenges, and today's agenda offers several proposals that could substantially affect the provision of these services. It is my sense that this Committee must carefully weigh the costs and benefits of these proposals, and consider them in the context of today's testimony as well as the views of the many veterans' organizations that have previously commented on these topics.

Mr. Chairman, our Nation's veterans remain a high priority for me; I look forward to working with you on their behalf.

Senator CRANSTON. I would like to turn now to your proposal for health insurance reimbursement. In connection with the third party reimbursement legislation it is my understanding that subscribers to health maintenance organizations, HMO's, are limited by the terms of their contract to receiving care in specific designated health-care facilities, and that except in the case of care provided in emergency situations, the HMO has no obligation to reimburse subscribers for care received from other than the designated facilities.

If legislation were enacted assuming VA facilities do not seek to become designated facilities, would the VA seek to obtain reimbursement from HMO's for nonemergency care?

Mr. IVERS. I believe we would, Senator, in that case, under those circumstances. I think the first step would be to have VA facilities designated. However, if they were not we would proceed to attempt to collect.

Senator CRANSTON. Does the same analysis apply to other situations, such as self-insured employers which limit reimbursement to care received in specific health-care facilities or from specific health-care providers?

Mr. IVERS. Except with the exception of those, there are some exceptions stated in our proposal. However, the same situation would apply in other than those exceptions stated in the proposal, the same circumstances.

Senator **Cranston**. Then unless the contract specifically recognizes the VA you would not proceed?

Mr. **Ivers**. No; I think we would proceed. But our first attempt would be to have the contracts specifically designate VA facilities. However, if they did not, we would proceed to attempt to collect.

Senator **Cranston**. OK. My time has expired.

Thank you.

Chairman **Murkowski**. Senator Mitchell.

Senator **Mitchell**. Thank you, Mr. Chairman.

Representatives from the Health Insurance Association and Blue Cross and Blue Shield of course oppose the proposal to require reimbursement. But they also say that if it is to occur, the insurance industry should be able to subject VA hospitals to the same type of review and cost-control measures that private hospitals are subject to.

In your view should the VA medical system be subject to such outside review and cost control? And would you be agreeable to it as part of this proposal?

Dr. **Gronvall**. I think the basic answer is, yes. And let me ask Ms. Quandt to expand on that.

Ms. **Quandt**. Senator Mitchell, I doubt that those who do not deal with us regularly realize the controls within the VA, and that in many respects we are paralleling the private sector in what we are doing. We are using the same DRG system that the private sector is using. They are having some of the very same effects that the private sector is having. It has made a major change in our length of stay. And we are at this point establishing a major MEDIPRO Program, which is called—our Medical Peer Review Organization. And it is so set up that no hospital is essentially reviewing its own specific records, but they are reviewed by an outsider.

The legislation which is proposed does carry a statement that insurance carriers will have the opportunity to review the clinical records. And on that basis we mean they will have the opportunity, given the authority and release from the specific patient, to look at a specific case.

Senator **Mitchell**. Well, indeed, your earlier testimony regarding the costs of treating persons 65 or older with respect to hospitalization reflects your conclusion that you are doing that cheaper than is being done in the private sector now, does it not?

Ms. **Quandt**. Correct.

Senator **Mitchell**. Well, I thank you.

I thank you, Mr. Chairman. I yield back the rest of the time.

Chairman **Murkowski**. Senator Rockefeller.

Senator **Rockefeller**. No questions, thank you.

Chairman **Murkowski**. Do you have further questions, Senator Cranston, on third-party?

Senator **Cranston**. I have got about 5 minutes more questions, then that is all that I have.

Chairman **Murkowski**. I would remind my colleagues that we also have the question of the Puerto Rican health-care issue to address to the panel. Senator Cranston, do you have questions on Puerto Rico as well?

Senator **Cranston**. No; I do not. Any that I have I will submit in writing.

Chairman MURKOWSKI. Please proceed.

Senator CRANSTON. I would like to have it understood for the record that you provide copies of all estimates that any office in the agency has ever prepared relating to the costs of administering the system of third-party reimbursements. Can you do that?

Chairman MURKOWSKI. Ever prepared?

Senator CRANSTON. Well, in the current context of these proposals.

Chairman MURKOWSKI. Well, I think we had better define "ever prepared."

Senator CRANSTON. Well, when have these proposals first begun to see the light? In 1979, I guess.

Chairman MURKOWSKI. I would hate to see the VA put on additional staff to get that information.

Ms. QUANDT. Senator Cranston, beginning with 1979?

Senator CRANSTON. Yes.

Chairman MURKOWSKI. Thank you.

[Subsequently, the Veterans' Administration submitted the following information:]

Numerous proposals have been put forth over the years that have involved the concept of third party reimbursement. The assumptions and data bases used have varied considerably over that period of time, making cost comparisons futile. Attached is the cost estimate for the current proposal.

FISCAL YEARS 1988-1990

Total potential billings would be the same as in fiscal year 1987 ($867,000,000) but collections would increase in these years as the VA's efficiency in pursuing collections is assumed to increase to: fiscal year 1988, $265,000,000; fiscal year 1989, $275,000,000; fiscal year 1990, $280,000,000.

7. Certain administrative costs would be associated with implementing a billing program of this magnitude.

Staffing and cost estimates are based on an additional workload of 250,000 bills prepared by the VA annually. Staff needed to obtain health insurance information and assignment of the claim from veterans are included in this estimate; these staff are not part of the implementing cost of "looking behind the oath", since income alone is the basic criteria of eligibility.

In developing the staffing costs, we have assumed that there will be a pay freeze for fiscal year 1986, and a 3 percent cost-of-living increase in each of the subsequent years.

Fiscal year 1986

Staffing (MAS): 47 FTEE, GS-5's	$862,391
Staffing (fiscal): 62 FTEE, GS-6's	1,264,567
Staffing (district counsel):	
1 FTEE, GS-13's	
1 FTEE, GS-7's	70,662
Billing forms	6,508
Mailing	55,000
Photocopying	11,316
Total FEE 111	$2,270,444

Fiscal year 1987

Staffing (MAS): 67.5 FTEE, GS-5's	$1,275,696
Staffing (fiscal): 91 FTEE, GS-6's	1,917,012
Staffing (district counsel):	
1 FTEE, GS-13's	
1 FTEE, GS-7's	72,781
Billing forms	6,508

Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	$3,338,313

Fiscal year 1988

Staffing (MAS): 67.5 FTEE, GS–5's	$1,313,967
Staffing (fiscal): 91 FTEE, GS–6's	1,974,523
Staffing (district counsel):	
1 FTEE, GS–13's	
1 FTEE, GS–7's	74,964
Billing forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	3,436,278

Fiscal year 1989

Staffing (MAS): 67.5 FTEE, GS–5's	$1,353,386
Staffing (fiscal): 91 FTEE, GS–6's	2,033,758
Staffing (district counsel):	
1 FTEE, GS–13's	
1 FTEE, GS–7's	77,214
Billing forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	3,537,182

Fiscal year 1990

Staffing (MAS): 67.5 FTEE, GS–5's	$1,393,988
Staffing (fiscal): 91 FTEE, GS–6's	2,094,771
Staffing (district counsel):	
1 FTEE, GS–13's	
1 FTEE, GS–7's	79,530
Billing forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	3,641,113

8. The following table summarizes collections, costs, FTEE, and net financial impact to the VA.

	Reimbursements to VA	Administrative costs	FTEE	Net financial impact to VA
Fiscal year:				
1986	$65,000,000	$2,270,444	111.0	$62,729,556
1987	247,000,000	3,338,313	160.5	243,661,687
1988	265,000,000	3,436,278	160.5	261,563,722
1989	275,000,000	3,537,182	160.5	271,462,818
1990	285,000,000	3,641,113	160.5	281,358,887

GOE Costs: fiscal year 1986—$70,662; fiscal year 1987—$72,781; fiscal year 1988—$74,964; fiscal year 1989—$77,214; fiscal year 1990—$79,530.

Medical Care Appropriation: fiscal year 1986—$2,199,782; fiscal year 1987—$3,265,532; fiscal year 1988—$3,361,314; fiscal year 1989—$3,459,968; fiscal year 1990—$3,561,583.

9. No additional appropriation has been requested in the fiscal year 1986 budget to cover administrative costs that would be incurred by the VA to implement this legislation.

10. A much earlier cost draft estimate was given to GAO as part of the Agency's comments on the GAO report "Legislation to Authorize VA Recoveries from Private Health Insurance Could Save Millions." Since that earlier draft was done, many assumptions and parameters for both implementation of the "means test" and for third party recoveries have been changed.

Senator **Cranston**. HIAA notes that private insurers would expect the VA to use the national billing form, UB-82, in order to pay a claim, and insurers would need information on the principal and other diagnoses and surgical procedures properly coded and patient history and physical information. Do your cost estimates for the implementation of this legislation take into account the costs of providing that kind of information?

Ms. **Quandt**. Our estimates do, Senator Cranston. We will be using UB-82. It is the nationwide form for such activity. And we can provide the diagnostic data, and treatment data required.

Senator **Cranston**. HIAA in its statement notes that—

> Insurers reap no extra benefit or profit from the exclusion of reimbursement for care in the VA because insurance premium rates are calculated to reflect actual claims experience and utilization.

This statement directly challenges the so-called windfall theory which holds that insurers have been charging veterans premiums for care that has not been covered.

I was satisfied when this issue was before the committee in 1980 that there was no validity to the windfall theory, but have again seen and heard references to it during the current debate on this issue. GAO in its recent report makes no reference to any windfall.

What is the VA's position on the windfall theory?

Mr. **Alvarez**. Senator, we have not—we do not have a position on the windfall theory. We have heard the term in discussions, also. But we ourselves have not taken a position on that.

Senator **Cranston**. So you do not allege there is a windfall then, I assume?

Mr. **Alvarez**. No, sir.

Senator **Cranston**. In its testimony, HIAA describes various efforts that health insurers currently have underway to reduce health-care costs, including preadmission review and certification, establishment of appropriate length of stay prior to admission, concurrent review of utilization, postadmission audits to verify the propriety of services, and second opinions for elective surgery. How could the VA, without accepting such controls from insurance carriers, submit valid claims under the terms of insurance contracts which require compliance with those controls as a condition of payment?

Ms. **Quandt**. Senator Cranston, I believe that we are complying with most of those controls within our own system. We have utilization review coordinators at every hospital. We have quality assurance coordinators at every hospital. Since we went into the DRG allocation system for all of our acute hospitalization, which is beyond what the private sector is doing, we have been using what are called DRG coordinators who determine the length, the appropriate length of stay, to which the physician must respond.

I previously stated that the use of DRG's have had the same effect with us; it has cut our length of stay. And we are in the process of going through the postadmission audit.

As far as a second opinion is concerned, Dr. Gronvall may wish to speak to that. That is available within our system.

Senator **Cranston**. The matter of compliance——

Chairman MURKOWSKI. Senator Cranston, your 5 minutes has expired.

Senator CRANSTON [continuing]. Would be something that a court would have to—the matter of compliance would be a matter that a court would have to determine, I assume.

I just have I think one last question, Mr. Chairman.

Assuming enactment of third-party reimbursement legislation in a case in which an insurance carrier refused to reimburse the VA for care provided to a veteran and the VA brought suit to recover the amount owed, would the VA also bring suit against the veteran?

Mr. IVERS. No.

Senator CRANSTON. This suggests that the underlying basis of the insurance companies opposition—that they are being made liable in a situation in which the insured has no liability is a valid contention.

Mr. IVERS. The contention that the insurance carriers are liable where the insurer is not?

Senator CRANSTON. Yes. That is their contention.

Mr. IVERS. There have been some court cases on that. And if I am not mistaken, I would like to submit an answer for the record, but if I am not mistaken there is a split opinion on that right now in the court system.

[Subsequently, the Veterans' Administration submitted the following information:]

The decisions turn on whether there is a statute which authorizes the United States to recover despite the lack of an obligation to pay on the part of the recipient of the care. For example, prior to the passage of the Federal Medical Care Recovery Act (FMCRA), the Supreme Court held, in *Standard Oil* v. *United States*, 332 U.S. 301 (1946), that, absent a statute, the Government could not recover the cost of care furnished a member of the Armed Forces injured as a result of tortious conduct. Once the FMCRA was passed, however, the courts upheld the Government's authority to recover such medical care costs. *United States* v. *Jones*, 264 F. Supp. 11 (E.D. Va. 1967). Similarly, with respect to the Government's right to recover under a no-fault automobile insurance policy, a Federal district court in Michigan held that, since Michigan had abolished tort liability and substituted no-fault, the FMCRA provided no basis for recovery and that the State's no-fault statute precluded recovery by the Federal Government. *United States* v. *Jackson*, 572 F. Supp. 181 (W.D. Mich. 1983). Where, however, 28 U.S.C. § 629 was for application, authorizing the VA to recover under no-fault, the State law was held to be preempted and of no effect to the extent it would have prevented reimbursement to the Veterans' Administration. *United States* v. *State Farm Insurance Company*, 599 F. Supp. 441 (E.D. Mich. 1984).

Senator CRANSTON. But you would not intend to sue the veteran?

Mr. IVERS. Not the individual veteran.

Senator CRANSTON. Thank you very much.

Thank you, Mr. Chairman.

Chairman MURKOWSKI. Thank you, Senator Cranston.

I am going to move into the Puerto Rican health-care issue. Evidently you have no questions on Puerto Rico?

Senator CRANSTON. No.

Chairman MURKOWSKI. Senator Rockefeller may have.

In light of the demands on VA resources in the continental United States, how do you justify the extension of the extraordinary authority to contract for care for non-service-connected veterans in Puerto Rico?

Dr. **Gronvall.** Senator Murkowski, as a general answer I would say we request the extention in order to continue delivering a pattern of care that has developed over the years in Puerto Rico and the Virgin Islands that we believe responds to the medical needs of veterans living there.

Chairman **Murkowski.** Yet you have only asked for a 3-year extension, and your obligation, obviously, is an extended one.

Dr. **Gronvall.** Yes. The present legislative proposal is for a 3-year extension. In the plans regarding Puerto Rico, we have described the establishment and expansion of additional medical programs and the outpatient clinic in Ponce, and the addition of psychiatric beds at our medical center in San Juan, which we believe over time will make it no longer necessary to use the special contract authority. And we would propose that it be phased out consistent with the implementation of——

Chairman **Murkowski.** Then what are you going to do when it is phased out?

Dr. **Gronvall.** All of the care that would be delivered in Puerto Rico would be delivered then through VA facilities, hospitals, outpatient clinics.

Chairman **Murkowski.** You anticipate then, what, a 9-year phaseout?

Dr. **Gronvall.** I would have to go back and look at a detailed projection of the total number of years. But it will be——

Chairman **Murkowski.** That is what it says.

Dr. **Gronvall** [continuing]. More than 3 years.

Chairman **Murkowski.** Senator Rockefeller, do you have any questions?

Senator **Rockefeller.** No questions.

Chairman **Murkowski.** If not, I would thank the panel of witnesses from the VA. I remind my colleagues that we have three other panels before us and it is 11:15. We have questioned you gentlemen and lady for the last hour and a half.

[The responses of the Veterans' Administration to written questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs; Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs; Hon. Arlen Specter, a U.S. Senator from the State of Pennsylvania; and Hon. George J. Mitchell, a U.S. Senator from the State of Maine; follow:]

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. If the Congress modified the Administration means test proposal so that the income and asset ceiling would be increased to $25,000, with no spend down provision and implementation date of October 1, 1985:

What is your estimate of the administrative costs necessary to implement such a modified proposal; and what is your estimate of the potential savings which could be achieved upon implementation.

Answer 1A. Our estimate of administrative costs is speculative, given the lack of precision in the data available with respect to veteran users of the VA health care system, their income,etc. The increase in the threshold to $25,000 would not reduce the number of patients who will require interview, although the number of appeals and billing cases will probably be fewer than if the threshold were twice the pension level. Bearing in mind the absence of precise data, we estimate the administrative costs as follows:

Interviews and Counseling	327,923 hours ÷ 1664 = 197 FTE
Appeals and Billing	12,374 hours ÷ 1664 = 7 FTE
	204 FTE

204 FTE @ Average Salary = $3,615,696

An estimate of "savings" is even more problematic in that we anticipate current demand is sufficient to maintain workloads at current levels with this new proposal. As a matter of equity, the neediest veterans subjected to the means test will be provided care.

Question 1B. What would the consequences be if a co-payment was added to allow certain veterans with incomes above $25,000 to receive VA care.

Answer 1B. Precise estimates of the impact of co-payments are also speculative, however, it has been shown that as co-payments increase,use of health care services decreases. It is expected that such a trend would be true of users of the VA health care system.

Question 2. Please explain what criteria the VA would establish for its definition of assets as used in the proposed means test eligibility requirement. Please list all the categories of assets which would be exempted.

Answer 2. A regulatory definition of assets to be used in the means test process has not yet been settled within the administration. It has been suggested that assets be considered in the same manner as the Department of Veterans Benefits determinations in the pension application process. If this is the case, exempted assets will be: donations from public or private relief or welfare organizations; proceeds of fire insurance policies; profit realized from the disposition of real or personal property other than in the course of a business; and amounts in joint accounts in banks and similar institutions acquired by reason of death of other joint owner.

Question 3. Considering the fact that costs are greater for inpatient health care than for outpatient care, please comment on whether it would be reasonable to establish different income thresholds for each, in lieu of the one eligibility level which is included in your legislative proposal.

Answer 3. One income threshold is preferred since the criterion is to determine if an individual is, or is not, able to defray the cost of needed health care, whether it be inpatient care or outpatient care.

Question 4. The VA's proposed means test would allow the Administrator to waive a veteran's medical expense contribution in exceptional and unusual circumstances to avoid substantial hardship. Please describe the criteria which would be used, and if certain catastrophic illnesses would be considered, please define what would be considered a catastrophic illness.

Answer 4. The waiver authority would be used on a case by case basis. The veteran would have to demonstrate that obtaining care from non-VA sources would effect an unusual and exceptional hardship on him/her. Certain catastrophic illnesses such as terminal cancer and end stage renal disease would be considered.

Question 5. Private health insurers have said that the Veterans Administration would have to develop a billing system acceptable to them in order to seek reimbursement for care provided to veterans. What changes in your cost accounting system do you plan to undertake to implement this proposal and how long would such changes take to be developed and implemented? To what extent would you be willing to subject your cost and accounting system to a review by third party payers?

Answer 5. The present billing system utilized by the Veterans Administration for interagency billings, private sector tort feasor, and ineligible hospitalization billings is based on VA national average per diem rates listed by twelve various categories of care. These data are based upon information derived from the experiences of the various services at each of the 172 VA medical centers and the report is then computer generated by individual VA medical center and national average rates. The rates are sent to the Office of Management and Budget annually for approval and publication in the Federal Register. In addition to Office of Management and Budget review, the General Accounting Office and the VA's Inspector General periodically review the procedures and reporting system used to generate the per diem rates. Changes in the cost accounting system would not be necessary based on the present rate system employed by the VA. An explanation regarding the procedures, methodology and systems used in deriving our per diem rates can be shared with the private sector.

Question 6. How would the Administration's third party reimbursement proposal affect health insurance systems, such as health maintenance organizations (HMO's) or large companies which provide medical facilities for their employees care?

Answer 6. The Administration's third party reimbursement proposal would prohibit health insurance contracts from specifically excluding payments to the VA but would not affect other terms of the policy. This means that if a veteran's HMO coverage would reimburse a private hospital, the VA would be entitled to reimbursement on the same basis. If the HMO coverage would not reimburse a private hospital for the same episode of care, then the VA would not be reimbursed.

Question 7. How would the Administration's third party reimbursement proposal take into consideration the differences between direct payment to providers of health care benefits versus reimbursement directly to the policyholder?

Answer 7. Under the proposal, all billing would be direct to the insurance carrier. The veteran policyholder will not be billed for VA services, will have no payment to make, and so will not be claiming reimbursement.

Question 8. How would the implementation of a means test for veterans in Puerto Rico change the estimated 3-year cost of $28.2 million which would be needed if the 3-year extension of contract authority were granted?

Answer 8. According to the most recent census figures, the median family income in Puerto Rico is less than $6,000 per year. We anticipate that most Puerto Rican nonservice-connected veterans will be eligible for VA care under the criteria of the proposed means test. Therefore, no change in the 3-year cost estimate of $28.2 million is anticipated.

Question 9. The VA Puerto Rico plan calls for an expansion of psychiatric care hospital beds in San Juan. Where does this project fit on the list of VA construction priorities? When will the VA request money for construction in Puerto Rico? Using your new method for prioritizing projects, please indicate the priority you would assign to the Puerto Rico project.

Answer 9. The current VA planning for San Juan calls for design of this medical center project in FY 1988 and construction in FY 1989, based on the FY 1985-FY 1989 Medical Facility Construction Needs Assessment. As a planning document, the needs assessment does not represent a final construction plan since projects listed and their tentative fiscal years are subject to change based on a variety of factors, including the VA's continuing assessment of program needs, planning refinements, statutory changes and policy guidance.

In response to the directive contained in Senate Report No. 98-506, which accompanied Public Law 98-371, the VA developed a new prioritization methodology to rank construction projects in priority order. This methodology is currently undergoing review and has not as yet been approved. Our initial assessment would indicate that San Juan would continue to be viewed as a high priority.

The San Juan project requires development through the advance planning fund process (APF) in order to accurately define the project scope and cost for budget consideration. Recently, the VA received approval from OMB of our request to notify Congress of our reprogramming proposal for an APF at San Juan. Such a request to Congress will be forthcoming.

Question 10. How would disputes between the Veterans' Administration and third party payers concerning billing issues be resolved?

Answer 10. Disputes that could not be resolved by administrative personnel at the local VA medical center would be referred to the appropriate District Counsel office. This procedure is followed in other cases such as Workers' Compensation where the VA is claiming reimbursement for medical care provided.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. If a veteran's insurance coverage is subject to deductibles or co-payments, does the VA intend to make its collections subject to the veteran's satisfaction of any requirements in the contract for payment of deductibles and co-payments?

Answer 1A. The Veterans Administration does not intend to make its collections subject to the veteran's satisfaction of requirements in the contract for payment of deductibles and co-payments.

Question 1B. If not, what is your response to the assertion of the insurance companies that relieving the veteran of such costs deprives them of the benefit of valuable disincentives to the overutilization of health-care services?

Answer 1B. The utilization of health care services in the Department of Medicine and Surgery is controlled by clinical professionals in the Department. Such professionals have no incentive to overutilise services and in fact, through the DM&S clinical reimbursement model, they have active disincentives to overutilization.

Question 2. GAO, in its report on third party reimbursement, asserted that insurance billing records could be incorporated records could be incorporated into the existing CARS system. Do you agree?

Answer 2. The Veterans Administration took exception to the GAO comment regarding the CARS system. The CARS system is currently running at capacity. It will require major reprogramming and upgrade to be useful for DM&S insurance billing purposes.

Question 3A. Dr. Gronvall, I have a number of questions regarding medical care account FTEE's. In each case, I am asking about so-called "total jurisdictional FTEEs", that is, the number of FTEEs not counting common services FTEEs.

First, how many medical care account FTEEs will the VA use in FY 1985?

Answer 3A. The VA projects the Medical Care FTEE usage through the end of FY 1985 to be approximately 192,500/193,000. This is between 600 and 1,100 FTEE over the middle column estimate for 1985 contained in the FY 1986 budget.

Question 3B. Assuming that a 5-percent federal civilian pay cut is not enacted and that, instead, federal civilian pay levels are frozen in FY 86, and that the FY 86 appropriation for the medical care account is $8.961 billion, how many FTEEs would you utilize in fiscal 86 under that account?

Answer 3B. The projected FTEE utilization is 183,838 which is 8,210 below the 1986 requested level of 192,048 and assumes that funds associated with the 5% pay cut ($202,974,000) are not restored. This estimate is based on maintaining a balanced program.

Question 3C(i). Based on the same assumptions regarding FY 86, if the FY 87 medical care appropriation were $9.206 billion, how many FTEEs would you use in fiscal 87?

Answer 3C(i). The projected FTEE utilization for FY 87 assuming non support of the 5% pay reduction and no additional employment for activations is 186,502. This projection also assumes the maintenance of a balanced program. This is the best estimate available at this time. The final 1987 estimate will depend on the policy developed in the FY 1987 process and the final results from the FY 1986 budget process and the FY 1985 actual results.

Question 3C(ii). How does that number compare with maintaining in FY 87 the 193,941 FTEE for which Congress appropriated funds in FY 85 and adding the number of FTEEs that would be needed in fiscal 87 to staff new activations planned for that year?

Answer 3C(ii). Maintaining the budgeted 1985 level of FTEE (193,941) and supporting additional FTEE associated with currently planned 1987 activations would require approximately 195,600 FTEE. The final 1987 estimate will depend on the policy developed in the FY 1987 process and the final results from the FY 1986 budget process and the FY 1985 actual results.

Question 3D(i).

Based on the same assumptions regarding FY 86, if the FY 88 medical care appropriation were $9.486 billion, how many FTEEs would you use in fiscal 88?

Answer 3D(i).

The projected FTEE utilization for FY 1988 assuming non support of the 5% pay reduction and no additional employment for activations is 185,835 FTEE. This projection also assumes the maintenance of a balanced program. This is the best estimate available at this time. The final 1988 estimate will depend on the policies developed for the FY 1987/1988 process and final results of the 1986 budget process and the FY 1985 actual results.

Question 3D(ii).

. How does that number compare with maintaining in FY 88 the 193,941 FTEE for which Congress appropriated funds in FY 85 and adding the number of FTEEs that would be needed in fiscal 88 to staff new activations planned for that year?

Answer 3D(ii).

Maintaining the budgeted 1985 level of FTEE (193,941) and supporting additional FTEE associated with currently planned 1987 and 1988 activations would require approximately 197,700 FTEE. This is the best estimate available at this time. The final 1988 estimate will depend on the policies developed for the FY 1987/1988 process and final results of the 1986 budget process and th FY 1985 actual results.

Question 4(i).

Would medical costs that the veteran's insurer has paid directly or for which it has reimbursed the veteran count toward meeting the veteran's expected medical expense contributions?

Answer 4(i).

Only the veteran's out-of-pocket costs would be counted.

Question 4(ii). Would insurance premiums paid by the veteran be counted as part of the expected contribution?

Answer 4(ii). Yes, the veteran's payments for insurance premiums would be counted as part of his expected medical expense contribution.

Question 4(iii). Would insurance premiums paid on behalf of the veteran, such as premiums paid by the veteran's employer, be counted?

Answer 4(iii). No. Premiums paid by third parties would not count toward the veteran's expected medical expense contribution.

Question 5A. Since your testimony provides very few details on how a means test would actually be implemented, I have a number of questions in this regard.

You indicate that a veteran's ability to pay will be determined based on the veteran's income and assets. Specifically, how would you define "income" and "assets" for this purpose, and do you intend to count the income and assets of family members?

Answer 5A. Income and countable assets would be dealt with in a fashion similar to the improved pension program. Income and assets of family members would also be dealt with as they are in the improved pension program.

Question 5B. Do you intend to count non-liquid assets such as real estate and automobiles?

Answer 5B. A personal residence and automobile would not be counted as liquid assets. Other real estate and personalty not needed for daily living would be counted.

Question 6A. What additional FTEE do you estimate will be needed to administer a means-test program?

Answer 6A. We estimate that 298 FTE will be needed to administer the program.

Question 6B. What will be the annual cost of that FTEE?

Answer 6B. The first year cost is estimated to be slightly more than 5 million dollars.

Question 7. Do you estimate significant regional differences in the impact of the means test that would result in substantial reductions in patient load in some areas and little change in the number of veterans seen in other areas?

Answer 7. We do not anticipate substantial regional impact variations.

Question 8. What is your best estimate of the number of veterans age 65 and older who would be made ineligible under a means test if your proposal is enacted who would be eligible for Medicare?

Answer 8. We estimate that 41,000 veterans, eligible for Medicare, would be made ineligible for VA care through this proposal.

Question 9. As a result of Medicare deductibles and copayments, what would the average cost to the veteran be under Medicare for care that would previously have been provided by the VA directly?

Answer 9. Costs to veterans displaced to Medicare covered health care would vary widely. The current Medicare deductible is $400. Between day 60 and 90, the inpatient co-insurance is $100 per day. Outpatient charges are 20% of the allowable charges.

Question 10. What is the comparison between the average cost to the Federal Government of an episode of care provided to veterans through the VA and the average cost to the Federal Government under Medicare?

Answer 10. The Veterans Administration has not yet been able to get adequate data to compare full costs of Medicare payments, including Parts A & B, in order to make such a comparative study with Medicare. Such data will soon be available. A study of comparative costs using 1982 reimbursement data from the State of Maryland shows VA costs to be comparable to those of Maryland when adjusted by DRGs for casemix. According to the Health Care Financing Administration (HCFA), the average reimbursement per person served by the Medicare Program in 1984 was $5,174 for inpatient hospital services and $710 for physician services - a total of $5,884. Including the one-day deductible of $356, this would make the average Medicare case $6,240. The VA estimates its costs per person hospitalized at $6,003 for 1984, including physician costs. The Medicare cost of $5,884 covers inpatient hospitalization and supplementary medical insurance (Medicare Parts A & B), which includes physician and other medical services. The VA cost estimate of $6,003 is an all inclusive figure that covers inpatient and outpatient care as well as physician costs. It also includes an additional 9% of VA per-person cost for "debt financing" so as to make VA costs more comparable to those of the private sector, which has to pay the cost of borrowing money.

Question 11A. What is the VA's best estimate of the number of veterans who at the time they receive VA care for non-service-connected conditions have valid health insurance which would cover part or all of the cost of that care?

Answer 11A. The proposal is to bill the insurance carriers of non-service connected veterans. Service connected veterans being treated for non-service connected conditions will not be subject to this program. It is estimated that 13.2% of the non-service connected veterans have insurance that would cover VA services. This translates to coverage of roughly 277,000 non-service connected patients.

Question 11B. What is the basis for that estimate?

Answer 11B. In June of this year, the VA reviewed 16,400 records of active non-service connected patients to determine the extent of insurance coverage. The results of this sample were applied to the total non-service connected population to project estimates.

Question 12. What consideration, if any, has been given to contracting out the billing of insurance companies if third-party reimbursement legislation were enacted?

Answer 12. Serious consideration has been given to contracting out the billing but it has been decided that to do so would be impractical. The bill is derived from a review of the original medical record. Once the review is completed, bill preparation is simply done. It is not thought to be practical to forward the original medical record, or a copy, to a contractor to prepare a bill. Questions of protecting the privacy interests of patients also mitigates against contracting out this function.

Question 13A(i). Section 601(4)(C)(v) of title 38 authorizes the VA, in Puerto Rico, the Virgin Islands, and elsewhere outside the 48 contiguous States, to provide contract "obviate" care for non-service-connected disabilities so long as the VA patient workload in the area involved does not exceed the VA patient workload in the contiguous States. Section 601(4)(C)(v) also provides the VA with the authority to waive the patient workload restriction on the exercise of this contract authority.

Has the VA ever exercised the waiver authority?

Answer 13A(i). Yes.

Question 13A(ii). (If Yes) Please state when and provide a full description, in each case, of the waiver itself and of its justification, and copies of the waiver documents themselves.

Answer 13A(ii). The VA has exercised the waiver authority. Although such authority has not been explicitly invoked by formal memorandum, it has been implicitly used by the budgeting process which has consistently assigned workloads, and the resources to support such workloads, that exceed those of the contiguous United States.

Question 13B. Please describe what, if any, plans the VA has for the use of the waiver authority in the future if legislation extending it beyond September 30, 1985, is enacted.

Answer 13B. It is expected that the waiver authority will be exercised in the future in the same fashion as this fiscal year.

Question 14.

Mr. Ivers, the administration's proposed means test legislation (in proposed new subsection (b) (5) of section 622 of title 38, United States Code) would allow the granting of waivers of the expected medical expense contribution "in exceptional and unusual circumstances, and to avoid substantial hardship." However, such waivers could "not be granted categorically, either for categories of illness, expenses, income, procedures, types of care, or veterans." In your oral testimony, you stated that this provision would not preclude binding guidelines requiring the granting of waivers to all catastrophically disabled veterans.

I would like to have further clarification of the prohibition of categorical waivers.

A. Could the implementing regulations require that waivers be granted, at least in part, to all veterans in state or other area in which medical costs are extraordinarily high?

B. Please provide examples of other situations under which the regulations could require the granting (or denial) of waivers to veterans who meet specified criteria.

C. Please describe exactly what the bar against categorical waivers is intended to prohibit.

Answers 14A, 14B, and 14C.

In developing the means test proposal, we recognized that in setting a general policy, our implementing regulations should not be so rigidly drafted as to effect serious hardship on veterans with unique financial and medical circumstances. Thus, we provided for a waiver authority which envisions that those regulations would permit the Agency in exceptional and unusual circumstances, and to avoid working a hardship on an individual veteran, to waive a portion or all of that individual's expected medical expense contribution. What you have characterized as the "bar against categorical waivers" is simply a policy that waivers are to be based on the circumstances of each individual case. To provide that broad categories of veterans would be granted a waiver without regard to all the relevant circumstances of each individual's case would be an unwarranted approach based on irrebutable presumptions rather than facts. Rather than helping to cure the inequity in existing law under which age is a basis for eligibility for medical care, it would substitute factors which may or may not in a given case cause hardship and warrant a waiver.

Question 15. Attached to these questions is a copy of a July 2, 1980, letter from the Disabled American Veterans's then-National Director of Services, Norman B. Hartnett, which enclosed a V.A. document that discussed the V.A.'s estimate of the cost savings that would result from enactment of third-party reimbursement legislation. Please comment on the authenticity of the V.A. document and discuss the differences between that estimate and the Agency's current estimate on the savings associated with such legislation.

Answer 15. It is not possible to verify the authenticity of the Controller Highlight enclosed with your question. Such Highlights have no archival value and are kept for short periods of time following issue. Although revenue estimates emanating from third party collection efforts can fluctuate widely depending upon the assumptions used for estimates, it is difficult to imagine a scenario constructed by the previous administration that would produce no savings whatsoever.

Question 16. Please describe your understanding of the relationship between the cost to the Federal Government of an episode of care for an individual in the VA as compared to the same care in non-VA facility reimbursed through Medicare.

Answer 16. The Veterans Administration has not yet been able to get adequate data to compare full costs of Medicare payments, including Parts A & B, in order to make such a comparative study with Medicare. Such data will soon be available. A study of comparative costs using 1982 reimbursement data from the State of Maryland shows VA costs to be comparable to those of Maryland when adjusted by DRGs for casemix. According to the Health Care Financing Administration (HCFA), the average reimbursement per episode of care paid by the Medicare Program in 1984 was $5,174 for inpatient hospital services and $710 for physician services - a total of $5,884. Including the one-day deductible of $356, this would make the average Medicare case $6,240. The figure of $5,884 includes inpatient hospitalization and supplementary medical insurance (Medicare Parts A & B), which includes physician and other medical services. The VA estimates its costs per episode of care for 65 years or older per person hospitalized at $4,311 for FY 1984. The VA cost estimate of $4,311 is an all inclusive figure that covers inpatient and outpatient care as well as physician costs. It also includes an additional 9.8% per VA episode cost for "debt financing" in order to make VA costs more comparable to those of the private sector, which pays the cost of borrowing money. If VA were to use its cost per person (allowing for a 1.5% re-admission rate), the cost per year in FY '84 would have been $6,486.

Comparing hypothetical data used by HCFA to estimate cost shift based on VA eligibility changes for FY '86, HCFA estimated costs per person for Parts A & B to be $5,233. VA estimates a cost of $5,159. This assumes a shift of 10,000 patients from VA to Medicare. This analysis shows there are virtually no differences in outlays from the federal budget for caring for these patients under Medicare or the VA. It should be noted, however, that Medicare carries with it costs to the patient in the forms of co-payments and deductables, as well as significant out of pocket costs for outpatient drugs, appliances, etc. Further, in many instances at least, it is said that private insurance is cross subsidizing Medicare patients. The VA, on the other hand provides full services, including drugs and appliances and requires no cross subsidization.

Therefore, the costs to the federal budget are very similar, but the total costs to the patient and society appear to be higher under Medicare.

Question 17. Is the intent of a means test to refer to other sources veterans who can afford care and thus to use VA resources only for the financially neediest veterans? Would a veteran with health insurance that would cover all or nearly all the cost of care be given care at the VA regardless of his or her income and assets?

Answer 17. It is the intent of the means test to refer to other sources nonservice-connected veterans who have sufficient income or assets to pay for their care. The presence or absence of health insurance is irrelevant for purposes of the means test. Applicants with or without insurance will be treated equally.

Question 18. Do you anticipate providing for regional variations in setting income and asset qualification levels that would reflect regional differences in the cost of health care in the community?

Answer 18. We do not propose regional variations in the means test. Areas of the country which have high income relative to other areas have high medical costs as well so the proportionality and equity issues are harmonized.

Question 19A. What criteria do you anticipate using to consider requests by a veteran that the V. A. waive all or part of the veteran's expected medical expense contribution?

Answer 19A. Although the criteria that will be used for waivers has not been finalized, it is expected that elements of extreme financial hardship and lack of suitable care in the private sector would be considered.

Question 19B. Who will decide such requests and will there be an appeal?

Answer 19B. Waiver authority will be vested in the Administrator of Veterans Affairs who may delegate action to the Chief Medical Director. As the waiver application is in effect an appeal, no further review is anticipated.

Question 20. Has the V.A. made any analysis of where veterans turned away from V.A. care by virtue of a means test might go to receive needed care and the extent to which some or all of their care might be paid for under other Government programs? If so, what has it shown?

Answer 20. The V.A. has analyzed the effect on those over 65 years old. It is believed that some 90 percent of those who would be ineligible, would use Medicare. This would involve somewhat more than 41,000 individuals. These estimates were derived from V.A. data bases in conjunction with income levels provided by the General Accounting Office.

Question 21. The Blue Cross/Blue Shield testimony discusses preferred provider organizations -- P.P.O.s -- arrangements which involve higher rates of reimbursement when the insurers use certain hospitals and facilities that have agreed in advance to provide health-care services to covered individuals for lower prices or with more stringent utilization controls. Would the V.A. seek to become a P.P.O. in communities in which that option is available?

Answer 21. The VA has not specifically explored the possibility of becoming a preferred provider, but such an option has not been ruled out.

Question 22. Does the V.A. intend to collect from third-party insurers for both in- and out-patient care provided to veterans?

Answer 22. The initial emphasis will be on inpatient billing due to greater return on investment, but we do intend to bill for outpatient care when it is covered.

Question 23A. What estimates has the agency made of the administrative costs of implementing a system of third-party reimbursement?

Answer 23A. The Agency has estimated administrative costs to be somewhat less than four million dollars.

Question 23B. For the record, please provide copies of all estimates that any office in the agency has ever prepared relating to the costs of administering a system of third-party reimbursement.

Answer 23B. Numerous proposals have been put forth over the years that have involved the concept of third party reimbursement. The assumptions and data bases used have varied considerably over that period of time making cost comparisons futile. Attached is the cost estimate for the current proposal.

	Fiscal Year 1987
Staffing (MAS) 67.5 FTEE, GS-5s	1,275,696
Staffing (Fiscal) 91 FTEE, GS-6s	1,917,012
Staffing (District Counsel) 1 FTEE, GS-13s 1 FTEE, GS-7s	72,781
Billing Forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	$3,338,313

	Fiscal Year 1988
Staffing (MAS) 67.5 FTEE, GS-5s	1,313,967
Staffing (Fiscal) 91 FTEE, GS-6s	1,974,523
Staffing (District Counsel) 1 FTEE, GS-13s 1 FTEE, GS-7s	74,964
Billing Forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	$3,436,278

	Fiscal Year 1989
Staffing (MAS) 67.5 FTEE, GS-5's	$ 1,353,386
Staffing (Fiscal) 91 FTBE, GS-6s	2,033,758
Staffing (District Counsel) 1 FTEE, GS-13s 1 FTEE, GS-7s	77,214
Billing Forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	$3,537,182

	Fiscal Year 1990
Staffing (MAS) 67.5 FTEE, GS-5s	$ 1,393,988
Staffing (Fiscal) 91 FTEE, GS-6s	2,094,771
Staffing (District Counsel) 1 FTEE, GS-13s 1 FTEE, GS 7s	79,530
Billing Forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 160.5	$3,641,113

Fiscal Years 1988 - 1990

Total potential billings would be the same as in Fiscal Year 1987 ($867,000,000) but collections would increase in these years as the VA's efficiency in pursuing collections is assumed to increase to:

(Millions)	
Fiscal Year 1988	$265
Fiscal Year 1989	$275
Fiscal Year 1990	$280

7. Certain administrative costs would be associated with implementing a billing program of this magnitude.

Staffing and cost estimates are based on an additional workload of 250,000 bills prepared by the VA annually. Staff needed to obtain health insurance information and assignment of the claim from veterans are included in this estimate; these staff are not part of the implementing cost of "looking behind the oath", since income alone is the basic criteria of eligibility.

In developing the staffing costs, we have assumed that there will be a pay freeze for FY 1986, and a 3% cost-of-living increase in each of the subsequent years.

	Fiscal Year 1986
Staffing (MAS) 47 FTEE, GS-5s	862,391
Staffing (Fiscal) 62 FTEE, GS-6s	1,264,567
Staffing (District Counsel) 1 FTEE, GS 13s 1 FTEE, GS 7s	70,662
Billing Forms	6,508
Mailing	55,000
Photocopying	11,316
Total FTEE 111	$2,270,444

8. The following table summarizes collections, costs, FTEE, and net financial impact to the VA.

	Reimbursements to VA	Administrative Costs	FTEE	Net Financial Impact to VA
FY 1986	65,000,000	2,270,444	111	62,729,556
FY 1987	247,000,000	3,338,313	160.5	243,661,687
FY 1988	265,000,000	3,436,278	160.5	261,563,722
FY 1989	275,000,000	3,537,182	160.5	271,462,818
FY 1990	285,000,000	3,641,113	160.5	281,358,887

GOE Costs:

FY 1986 = $ 70,662
FY 1987 = $ 72,781
FY 1988 = $ 74,964
FY 1989 = $ 77,214
FY 1990 = $ 79,530

Medical Care Appropriation:

FY 1986 = $2,199,782
FY 1987 = $3,265,532
FY 1988 = $3,361,314
FY 1989 = $3,459,968
FY 1990 = $3,561,583

9. No additional appropriation has been requested in the Fiscal Year 1986 budget to cover administrative costs that would be incurred by the VA to implement this legislation.

10. A much earlier cost draft estimate was given to GAO as part of the Agency's comments on the GAO report "Legislation to Authorize VA Recoveries from Private Health Insurance Could Save Millions." Since that earlier draft was done, many assumptions and parameters for both implementation of the "means test" and for third party recoveries have been changed.

Question 24. Please comment on the statement in C.B.O.'s testimony that the available evidence suggests that veterans eligible under present law who seek V.A. hospital and clinical care do, in fact receive it; consequently there would likely be almost no substitution of these patients if the means test were enacted.

Answer 24. Other evidence, such as the 1984 and 1985 survey of demand, indicates that many veterans seeking medical care are not provided such care in a timely manner. Those needing intermediate level medical care or rehabilitation medicine services may wait lengthy periods before being scheduled for admission.

Implementing a means test would, in all probability, a) prevent some veterans who need medical care from obtaining it, and b) result in some substitution of those now receiving care for those now demanding it but not receiving it. Of course, the number of such beneficiaries, and their geographic distribution, can only be estimated using appropriate models and data.

Question 25. Please comment on the statement in the C.B.O. testimony that "waiting lists for V.A. hospital care do not exist as they are very short except in three of the 172 V.A. hospitals."

Answer 25. The existence and maintenance of waiting lists varies considerably from facility to facility. The use of formal waiting lists as a tool to predict unmet demand is simply too imprecise for practical use. Invariably, formal waiting lists are used only for applicants for long term care and many facilities do not maintain these formal lists due to the remote likelihood of listed patients being admitted in the near future due to low turnover in such units. Most facilities advise non-service connected applicants that their chances of admission for long term care are very dim and they do not list them on the waiting list as it raises unrealistic expectations of admission.

Question 26. On page 3 of your statement, it is noted that the proposed means test legislation would "clarify and extend a framework" which Congress provided for by the enactment of Public Law 96-330. Following up on the chairman's questions on this point, what specifically in the proposed legislation, other than applying a means test to veterans age 65 and older, cannot be done administratively under current law?

Answer 26. We acknowledge that under section 401 of Public Law 96-330 and section 621 of title 38, United States Code, VA does have authority to impose a means test. To achieve a more equitable and workable mechanism, however, we have proposed a more far-reaching proposal than what could have been promulgated under existing law. For example, rather than simply to set a monetary threshold and deny care to those above that limit, as some have proposed, our draft bill would authorize veterans with income and assets above specified limits to obtain care, subject to an expected medical expense contribution. It is questionable whether VA would have authority to waive that contribution from certain veterans, as provided under our proposal. The proposal also anticipates that veterans who apply for care but do not meet VA's threshold income test (approximately $15,000 under the proposal) would nevertheless be examined to rule out any emergency. It is questionable whether, under existing law, VA would have authority to bill the veteran for that examination up to his expected medical expense contribution, as proposed.

Question 27. As I asked during the hearing, I'd like to get your reactions to an alternative to your proposal to make veterans age 65 and older subject to a means test. Let us assume that the Congress enacted legislation establishing a statutory priority for inpatient and outpatient care listing all categories eligible for V.A. care, with veterans who are unable to defray the cost of the needed care given priority over veterans age 65 and older who do not meet that test. Wouldn't that address your concerns about the "fairness" of the current system without taking away anyone's eligibility?

Answer 27. No, even though it would be closer to the goal we hope to achieve by submitting this legislation. If we understand this alternative arrangement, it still appears to provide what we consider to be an unfair preference for veterans over age 65, as compared to younger veterans in similar financial circumstances, all other eligibility factors being constant. We believe any eligibility scheme which uses age alone as a discriminator with respect to the issue of ability to defray medical expenses is simply not fair.

Question 28. Would the provision in your draft legislation which would add a new subsection (K) to Section 629 relating to making clinical records of a veteran available to insurers allow the V.A. to provide third-party payors with access to all V.A. records necessary for their review of the claim and would the V.A. do so?

Answer 28. If a law was enacted which allowed insurers to review relevant clinical records, the VA would obey the law.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Question 1. How many veterans in the United States and specifically in Pennsylvania would not be eligible for VA health care benefits if the Administration's proposals regarding means tests and health care eligibility for veterans 65 years of age and older were enacted? Please provide these figures for the next 15 years.

Answer 1. Based on the General Accounting Office's report of May 3, 1985 (B-21894), we have estimated that perhaps as many as 186,554 persons would lose eligibility as a result of the means test proposed. Of this number, about 46,000 were 65 years old or older in 1980 and 1981. Presumably they were eligible for Medicare at that time and are so today. We cannot estimate from this database what impact would be seen in Pennsylvania. Data that would permit a State by State analysis is unavailable as is data that would permit discrete year by year analysis for the next 15 years. However, given the trend in the aging of the veteran population, and the known relationship that income decreases with age, it is assumed that the number of veterans who will lose eligibility will be a declining one.

Question 2. What would be the average cost to these veterans, and where would they obtain health care? Please provide examples of the costs to veterans at different income levels.

Answer 2. There are no data available for estimating the average additional expenses for veterans as a result of a means test. Each individual nonservice-connected veteran excluded from VA care may become eligible after meeting a required medical expense contribution that varies depending on income level. Veterans excluded from VA care would obtain health care from non-VA sources.

Question 3. How many veterans in the U.S. and in Pennsylvania do you believe would not receive proper health care as a result of these proposals? Please explain.

Answer 3. The basic principle of a means test is to screen out those nonservice-connected veterans who are determined to have the means to obtain health care from non-VA sources. VA health care resources can then be directed toward service-connected veterans, former POWs, veterans exposed to Agent Orange or ionizing radiation, pensioners, WWI, Spanish-American War, Mexican border period, and other nonservice-connected veterans who are truly needy. It is assumed that those veterans who are determined to have the means to obtain health care from non-VA sources will do so. Therefore, they would receive proper health care.

Question 4. How many veterans in the U.S. and in Pennsylvania would be forced to utilize Medicare or Medicaid as a result of these proposals? Please explain.

Answer 4. As indicated above, we estimate that approximately 186,554 veterans who used the VA in 1980-81 would have lost eligibility based on the Administration proposal. About 46,000 were 65 years old or older at the time and presumably would be eligible for Medicare now. Those under 65 would not be eligible for Medicaid. The income threshold for Medicaid varies by State but is so substantially below that of the Administration proposal to virtually assure that any Medicaid eligible veteran would also be VA eligible.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Question 1. In your testimony today, in discussing the means test, the VA says that "we project that the proposal would result in a lower rate of growth in VA's medical care and construction budgets than otherwise would be needed, while at the same time insuring the availability of resources to sustain a quality health care system for veterans." Where do the savings come from? Are they from personnel, construction, contract care, or other areas?

Answer 1. The testimony was meant to convey the notion that the demand for services in the VA medical care system is sensitive to the size of the pool of potential users of that system. If the pool of potential users is reduced, so too is the rate of growth necessary to match demand. Lower growth presumably reduces the need for as much construction, personnel, contract care, etc., but the degree to which that is true is not specifically known at this time.

Question 2. The proposal for the means test calls for nonservice-connected veterans to make some copayment of the cost of veteran's VA medical care. This so-called out-of-pocket expenses ("expected medical expense contribution") provision requires higher-income veterans to finance a larger amount of their medical expenses before entering the VA system.

Would that share ever be 100% under the VA's proposal? Should either the percentage share or absolute dollar amount vary by region, as an example, to account for differences in per capita income or the cost of health care in private medical facilities? Does the proposal include an annual cap on the amount any veteran is expected to pay for his or her health care before becoming eligible for VA health care?

Answer 2. There is nothing in the Administration proposal which requires a veteran to pay 100% of his expenses. It should be recognized that the veteran with a higher income may pay close to 100% of his expected medical expense contribution because of lower expense levels than poorer veterans. The cap refers to income level, not to an annual cap on payment expenses. We do not propose regional variations in the means test. Areas of the country which have high income relative to other areas have high medical costs as well, so the proportionality and equity issues are harmonized.

Question 3. Your testimony indicates that in "emergency or extraordinary circumstances," nonservice-connected veterans could be admitted to VA medical facilities but would be required to pay a portion of their VA medical expenses. Your statement goes on to say that in "exceptional and unusual circumstances," the Administrator could waive in whole or part the veteran's expected medical expense contributions in order to avoid substantial hardship. Please distinguish for me the differences between "emergency or extraordinary circumstances" on the one hand and "exceptional and unusual circumstances" on the other.

Answer 3. The "emergency or extraordinary circumstances" language refers to a hypothetical situation in which an applicant is seriously ill, has a catastrophic illness, is seriously distraught or in a state of such medical or psychiatric distress that attempts to interview and counsel over the means test would be impractical or inhumane. In these circumstances, the patient would be admitted but, if their assets and income were over the limits, would be required to reimburse the VA the amount they could have been required to pay as part of their expected contribution. Of course, such payment would not exceed the costs to the VA.

On the other hand, the "exceptional and unusual circumstances" involve the issue of dealing with an applicant's financial situation as it relates to his/her need for care. The Administrator would have authority on a case-by-case basis, upon application from a veteran, to waive all or part of the "expected medical expense contribution." This would be done in rare cases to prevent financial hardship to the veteran. Such a waiver does not envision categorical exceptions, such as a specific illness, procedure, type of care, and so forth.

Chairman **Murkowski**. The witness from the Congressional Budget Office is Dr. Nancy M. Gordon, Assistant Director for Human Resources and Community Development. We welcome you to the hearing. We are interested in a specific area that has come up for discussion previously under the means test with regard to the suggested cost savings in the implementation of the means test.

My spread sheet indicates an overall savings. Yet testimony previously given here seems to indicate that it is a matter of equity with the VA; the cost savings are not really cost savings in the true sense of the word; and there is not necessarily any substantive increase in costs because the costs will be assimilated through efficiencies within the VA. Yet, under your CBO overall savings you indicate $420 million in 1986, and $1.58 billion through 1990.

Tell us a little bit about that difference of opinion. Are you being conservative, extraordinarily liberal, or what?

TESTIMONY OF DR. NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC, ACCOMPANIED BY DOROTHY AMEY, ANALYST; AND NINA SHEPHERD, ANALYST

Dr. **Gordon**. Thank you, Mr. Chairman. Perhaps I might start by introducing the two Congressional Budget Office [CBO] analysts who work in this area: Dorothy Amey, who is seated to my left, and Nina Shepherd, who is seated to my right. We do have a prepared statement that we would like to have included in the record.

Chairman **Murkowski**. It will be included in the record.

Dr. **Gordon**. Thank you very much.

I think that the basic issue that you are raising has two points. The first has to do with the number of veterans who would no longer be eligible for care. And the second has to do with the extent to which there are veterans who would remain eligible for care under the means test and who would in fact apply for that care.

Chairman **Murkowski**. Why do we have this discrepancy, though, between the VA and your position? The VA says there will be no savings.

Dr. **Gordon**. I believe that the Veterans' Administration's [VA's] estimates of the numbers of veterans who would be made ineligible are lower than ours. We believe our estimates of the numbers of veterans who would be made ineligible are very conservative.

Chairman **Murkowski**. Have you conversed with the VA and sat down and discussed this?

Dr. **Gordon**. Yes.

Chairman **Murkowski**. And you are still at odds?

Dr. **Gordon**. We have had extensive discussions with VA staff, and there is a basic difference of opinion.

Chairman **Murkowski**. Why? Why can't you convince them or why can't they convince you?

Dr. **Gordon**. It is not clear to me, sir, why it is that——

Chairman **Murkowski**. They won't follow your position?

Dr. **Gordon**. That is right.

Chairman **Murkowski**. Is that a pattern?

Dr. GORDON. No, sir.

Chairman MURKOWSKI. I see.

Dr. GORDON. We generally have good analytic relations with the administration. Sometimes they provide information we did not have before. One of the difficulties is that some of the VA data has not yet been made available.

Chairman MURKOWSKI. Has that data not been made available?

Dr. GORDON. The data has not been made available to us yet. The VA has provided certain tabulations on some data, but not the raw data themselves.

Perhaps I could make two points about the question of the numbers of veterans who would become ineligible and why we believe our estimates are conservative. The first point has to do with the fact that we have to use survey data on veterans' income, and survey data normally is found to underreport the incomes that people actually have. For that reason, we believe that more veterans would be made ineligible than our estimates show.

The second reason is that the estimates made by the Congressional Budget Office are based on income alone and do not have any assets reflected in them for two reasons: One, the asset test was not specified in detail by the administration; and, two, the data that deal with assets are very poor. For both those reasons, we believe that the estimates of the numbers of veterans who would be made ineligible are quite conservative.

Chairman MURKOWSKI. Well, they figure 21,000 and you figure 8,000?

Dr. GORDON. I believe those are estimates of the——

Chairman MURKOWSKI. Standing in line.

Dr. GORDON [continuing]. Estimates of the number of veterans standing in line.

Chairman MURKOWSKI. And they figure 21,000; you figure 8,000?

Dr. GORDON. Right.

Chairman MURKOWSKI. That is quite a difference.

Dr. GORDON. I should point out that if they are correct about the 20,000 veterans on waiting lists, that would reduce the CBO estimated savings by at most 20 percent. That amount would not be sufficient to reduce those savings to the VA's estimate, which is essentially zero.

Chairman MURKOWSKI. The point was made in testimony, I think by Senator Mitchell, of the tremendous increase in eligibles because of the aging of the veterans. You have taken that into consideration?

Dr. GORDON. Yes, we have.

Chairman MURKOWSKI. Well, I suppose we could ask you to stay here for the test of time, but that seems hardly fair.

If Congress modifies the administration's means test proposal to provide for an income and asset level of, say, $25,000, with no spend-down provisions, and an implementation date of October 1985, or thereabouts, could you give us what you might estimate the potential savings to be?

Dr. GORDON. Yes. If the administration's proposal were to be enacted——

Chairman MURKOWSKI. At 25, with no spend-down.

Dr. GORDON. The estimates, the numbers that we have with us this morning would have a phasein on this proposal—not complete implementation, by October 1.

Chairman MURKOWSKI. There would be a phasein——

Dr. GORDON. Right.

Chairman MURKOWSKI [continuing]. Over how long?

Dr. GORDON. Over 7 months.

Chairman MURKOWSKI. Seven months. OK, go ahead.

Dr. GORDON. Under those circumstances, the 1986 reduction in outlays is estimated to be $190 million.

Chairman MURKOWSKI. A $190 million for fiscal year?

Dr. GORDON. That would be for fiscal year 1986.

Chairman MURKOWSKI. Fiscal year 1986. Savings as compared to what for the $15,000 threshold for the same period?

Dr. GORDON. If the annual income cutoff was $15,000, the savings would be $362 million.

Chairman MURKOWSKI. $362 million on $15,000 for fiscal year 1986.

Dr. GORDON. By 1990, when it is assumed that the proposal would be fully implemented, it would generate roughly 60 percent of the savings relative to the administration's proposal. Clearly, the savings would be higher in 1986 if the proposal could be implemented by——

Chairman MURKOWSKI. Earlier.

Dr. GORDON. If it could be implemented by October 1.

Chairman MURKOWSKI. I understand.

Dr. GORDON. Perhaps I should also mention that these numbers——

Chairman MURKOWSKI. Go ahead.

Dr. GORDON. I should also mention that these numbers include the reimbursement proposal from private insurers as well. If we were to look at the administration's proposal using the $25,000 income limit and consider only the savings from the means test, then we would have savings in 1986 to the VA budget of $131 million that would be offset in that year by roughly $25 million in the Medicare budget. That would be just over $100 million in net savings.

Chairman MURKOWSKI. Would there be a gain of 60 percent or a loss?

Dr. GORDON. There would be a loss of about 40 percent of the net savings, compared with the administration's proposal. About 60 percent of the net savings would be retained.

Chairman MURKOWSKI. OK.

Dr. GORDON. The discussion we just had includes the numbers for the reimbursement from private insurers. When you raise the income limit, then there are many more veterans who would remain eligible for VA care who have private insurance from which recoveries could be made.

Chairman MURKOWSKI. OK. Now, with or without the Medicare offset, is the $190 million with that, or without it?

Dr. GORDON. The $190 million reflects the offset.

Chairman MURKOWSKI. The offset. OK.

Dr. GORDON. That amount would be the net budgetary savings.

Chairman MURKOWSKI. OK. So that is the net figure for fiscal year 1986?

Dr. GORDON. Correct. And again——

Chairman MURKOWSKI. The VA does not agree with that?

Dr. GORDON. That is my understanding.

Chairman MURKOWSKI. And your understanding as to why the VA does not agree with that is specifically what?

Dr. GORDON. There are two basic factors. One has to do with estimates of the number of veterans who would become ineligible for care under the proposal. The second has to do with the extent to which there is unmet demand so that the veteran who no longer received care would be replaced by another veteran.

Chairman MURKOWSKI. In your examination of the VA as it functions, what is their ability, in your opinion, to forecast whether there is 8,000 or 21,000?

Dr. GORDON. I believe that the VA has some data that they have collected.

Chairman MURKOWSKI. Waiting in line.

Dr. GORDON. One of the difficulties is that the questionnaire that they use is a relatively recent one that they are in the process of examining and improving for future years.

Chairman MURKOWSKI. Well, it is fairly significant.

Dr. GORDON. Questions were asked about what type of care the veteran was seeking that was unavailable, but the tabulations that the Veterans' Administration has provided do not in fact differentiate between types of care. A clinic visit is so much less expensive than a hospital stay; indeed it is only 2 percent of the cost of a hospital stay. Therefore, it is crucial to be able to distinguish between those two types of demands. Perhaps even more important, the CBO numbers assume essentially no savings in the nursing home side because there are waiting lists for nursing home care in many of the local areas.

Therefore, if most of those requests for care that were denied were in fact for nursing home care, then you must set those aside when you try to estimate the savings from hospital care and outpatient care, which is where the CBO savings come from.

Chairman MURKOWSKI. Well, I don't know, the next time we have a hearing I think I will bring you up with the VA so we can have a little more give and take.

Dr. GORDON. It would be——

Chairman MURKOWSKI. The record is going to be open. The major concern of this committee is the question of whether the means test is worthwhile. The VA has come in and said it is from a standpoint of equity. Well, that is significant. But in itself, are there any savings, or are we just burdening the system with a redundancy of a bureaucratic expansion in paperwork?

Dr. GORDON. May I add something?

Chairman MURKOWSKI. You may.

Dr. GORDON. There were many questions about the increase in costs for Medicare that would occur if eligibility for VA services were reduced for those veterans age 65 and over. Based on current data, our estimates show that about half of the savings that the VA would achieve for elderly veterans would go toward paying higher Medicare costs. And it is possible that Medicare outlays would rise more than that. If more of the veterans who now say they are not eligible for Medicare would——

Chairman MURKOWSKI. What would you say to a suggestion that you and your staff and Ms. Quandt sat down and spent a little time on this specific issue of resolving whether there are savings or there are not savings? We can keep the record open for 10 days. Let's see if we can get something that you can agree on. I do not mean a forced agreement, but at least some qualifications. Because, you know, you are stating some significant figures that this committee has a responsibility to reflect on as to whether or not there are realistic cost savings.

Yet, the administrative agency that has the responsibility of disbursing health care gives us the opinion that there are no savings. Their support is based on the equity issue. That is meritorious on its own. But the realities of cost savings are reflected in cost savings for additional and expanded care for the veterans, and that is the responsibility of this committee.

I would ask rather than pursue it here, because I do not think this is quite the appropriate arena because you have not had a chance to reflect on it, if within the 10-day period you and the staff of the VA and your staff can meet on the specifics of just what this question is. Rather than providing a long narrative for my colleagues to reflect on, but rather a spread sheet showing the highs and lows and the qualifications of both your positions, and where, indeed, the savings might be gained.

More often than not my experience dictates to me that when an organization such as the Congressional Budget Office comes in with estimated cost savings, yet the agency that performs the service is told that they should be able to do this, when their opinion is that they cannot, that more often than not you are loggerheads and neither one of you get anywhere. I am willing to suggest this as an alternative means that may provide a responsible approach. I think it is worth a try.

Dr. GORDON. We would be pleased to sit down with them again, which we have already done several times. But may I suggest that the committee staff join us in those deliberations? I think that it might yield a more productive meeting than if the CBO staff and the VA staff were to simply repeat what we have already gone over several times.

Chairman MURKOWSKI. Is there any objection to that, Jon?

Mr. STEINBERG. No objection.

Chairman MURKOWSKI. All right. I would appreciate the cooperation of minority counsel and majority counsel. I would request that we keep the issues relatively quantifiable in the sense of not getting off on all types of tangents, but a realization of whether there are cost savings to be recognized or there are not.

All right, and Dr. Gordon——

Dr. GORDON. Yes.

Chairman MURKOWSKI [continuing]. Would be in the meeting, of course.

Dr. GORDON. Yes. I would be pleased to participate.

Chairman MURKOWSKI. All right. Anyone else that we would suggest be included?

Dr. GORDON. Well, I would assume that the two analysts——

Chairman Murkowski. Yes, all right.

Dr. Gordon [continuing]. That the two analysts here today would be present, as well as my deputy, Stephen Long.

Chairman Murkowski. That is fine. And you set a suitable time that—yes, and VA representatives.

I assume there is no objection from the VA to this. She is nodding "no." That is good.

Dr. Gronvall, we would expect him to be there.

Ms. Quandt. Or Dr. Ditzler.

Chairman Murkowski. Or Dr. Ditzler.

OK. Well, maybe we have got something going. Maybe we are just complicating it. But we are moving along.

Dr. Gordon. But if I might just say, Mr. Chairman.

Chairman Murkowski. You may. Go ahead.

Dr. Gordon. These estimates are very difficult to do. There are many different areas in which we have to make assumptions, and I think it would be very helpful to the committee to see essentially the sensitivity analysis of what happens. Unfortunately, CBO has to provide point estimates for you because it is hard to deal with budgets using ranges of numbers.

Chairman Murkowski. Well, it would save Senator Cranston and I a good deal of time and our staffs a good deal of time if we do not have to argue the merits of whether there are or are not cost savings.

Dr. Gordon. Certainly.

Chairman Murkowski. We have to rely on the best expert advice and opinions. If we can get a consensus on it one way or another, why, it saves us that exercise. If we cannot, why, then we are prepared to pursue the alternatives. But it would seem to me that since this is a major point and one of contention by all interested parties we should pursue it.

Yes, I think has been pointed out that it would be helpful if the VA would produce and make available the data before the meeting, OK? So we do not have to start studying it at the meeting. We can have had a chance to review it prior to the meeting, and then we can get into the give and take on it.

Dr. Gordon. In addition——

Chairman Murkowski. We are talking about the raw data.

Dr. Gordon. Yes.

Chairman Murkowski. That has been withheld from CBO that you referred to.

Dr. Gordon. Thank you very much, Mr. Chairman.

Chairman Murkowski. Has the VA responded to that yet or are they about ready to? Somebody can nod their head.

Ms. Quandt. Mr. Chairman.

Chairman Murkowski. Yes?

Ms. Quandt. I am not quite sure what raw data she is referring to. If she is referring to a special questionnaire that was done throughout the field in May, within the next 10 days that data will not be tabulated.

Chairman Murkowski. Is that what you are referring to?

Dr. Gordon. No. I understand that the most recent questionnaire is still in process. But there was one completed in January of 1984.

Chairman Murkowski. Is that ready?

Ms. QUANDT. We have supplied the two reports from that. If they want the computer tapes there is no reason they cannot have that.

Dr. GORDON. Yes. It is the computer tapes that are necessary for us to be able to look at the data in more detail.

Chairman MURKOWSKI. Have you supplied the computer tapes to Dr. Gordon's staff?

Ms. QUANDT. I would have to check on that, Mr. Chairman.

Chairman MURKOWSKI. Do you have the computer tapes, Dr. Gordon?

Dr. GORDON. We do not have them.

Chairman MURKOWSKI. You do not have them. You have asked for them?

Dr. GORDON. Yes, that's correct.

Chairman MURKOWSKI. Do you have copies of your correspondence asking for them?

Dr. GORDON. Not with me.

Chairman MURKOWSKI. No. But I mean——

Dr. GORDON. Yes.

Chairman MURKOWSKI [continuing]. You have them?

Ms. AMEY. We have requested certain information about the findings—the results of the 1984 survey of facilities. We have received some of that information from, I believe, the Chicago group that was processing the data. We hope to receive the additional information soon. If we do not, or if we are not able to determine from that information what we need to assess the amount of excess demand at the time of the survey, then the only thing we could possibly do would be to process the actual survey data ourselves.

Chairman MURKOWSKI. I am advised that the VA was asked to give that data to GAO 3 to 4 weeks ago at a meeting. The information of the Chair is that it has not been done. Whether that is true or not, I do not know. But evidently Dr. Gordon indicates that she does not have it. Ms. Amey indicates that part of it is coming in. I think in the spirit of a cooperative commitment that we all live under as bureaucrats that we have an obligation to move together as opposed to moving like crabs do. If you ever watch a crab, it moves, but kind of moves sideways.

I would hope that on these and other issues that we can move in a positive manner because, obviously, we are all in the same boat for the same purpose. So I detect a certain sensitivity out there. But I don't want to belabor. I think you have picked up my point.

I have no further questions of this panel. I look forward to the results of the meeting that is going to be scheduled by the professional staff of the committee. We look forward to the input and a resolve on this question of whether there are indeed savings or whether there are not.

Thank you very much.

Dr. GORDON. Thank you, Mr. Chairman.

[The prepared statement of Dr. Nancy M. Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office; and the CBO's responses to written questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DR. NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE

The Veterans Administration (VA) provides free or highly subsidized medical care to eligible veterans. Over the last two decades, the Congress has expanded the categories of veterans eligible for VA care, so that the number of patients served and the size of the system have grown more rapidly than the veteran population. Moreover, VA medical care is rapidly growing as a proportion of the total VA budget. With the aging of the World War II population--most of whom will be eligible for VA care by 1990 when they will have reached age 65--there are concerns about the future growth of the VA medical care budget and the VA's ability to serve all veterans in need of care.

At your request, I will present the Congressional Budget Office's (CBO's) analysis of the Administration's proposals to change the eligibility and payment provisions for VA medical care, concentrating on the following specific issues:

- How the Administration's proposals would change current law and practices;
- The likely effects of enacting the proposals on the current beneficiaries and the federal budget; and
- The sensitivity of these estimates to certain assumptions and data limitations.

THE ADMINISTRATION'S PROPOSALS

The Administration proposes to modify the VA medical and health care system by changing the eligibility rules that apply to veterans without service-connected disabilities, and by collecting from private insurers a portion of the costs of care provided to veterans covered under private policies. Under both current law and the Administration's proposals, the service-connected veteran--any veteran who has a permanent injury or illness contracted during service--would have priority in receiving VA medical services. Since 1970, veterans age 65 and older (and certain other veterans in special categories) have been eligible for most VA medical care without regard to their income, insurance coverage, or other financial status. In contrast, most younger veterans without service-connected disabilities--often called nonservice-connected (NSC) veterans--are eligible for free medical care only if they assert that they are unable to defray the costs of needed care elsewhere.

The proposal would eliminate the categorical eligibility of NSC veterans age 65 and older and would apply to them and to younger NSC veterans a test of their ability to pay. Nonservice-connected veterans would be eligible under the proposal, if they had countable family incomes and assets valued at less than twice the VA pension level, or if they had paid large amounts in medical expenses that reduced their remaining resources below that level, according to a special formula. 1/ Several groups of veterans would be exempt from the proposal, including pre-World War I and World War I veterans, former prisoners of war, veterans exposed to radiation or Agent Orange during service, and VA pensioners.

Another proposal would require the VA to bill the private insurers of NSC veterans for the costs of their care. Most private insurers currently do not reimburse the federal government for care given to veterans, except in certain cases involving accidental injuries or workmen's compensation benefits. If enacted at the same time as the means test, the VA would recover costs for only those insured veterans who also met the means-test eligibility criteria. Enactment of this reimbursement proposal without the means test would involve a larger portion of the VA patient population.

THE LIKELY EFFECTS OF THE PROPOSALS

To analyze the proposals, several profiles of the VA patient population were obtained from both administrative and survey data. This information was used to derive proportions of the NSC user population that would be affected by the proposals, if enacted. Estimates of the impacts on

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1. Detailed specifications of the Administration's proposals were obtained from the Office of Management and Budget in March 1985. The special formula for computing excessive out-of-pocket expenditures reported in those documents was used in the CBO analysis. Legislation recently submitted by the Administration would, however, leave the specific formula to be defined in regulations prescribed by the VA Administrator.

recipients and costs were derived by applying these proportions to the CBO projections of the numbers and characteristics of VA hospital, clinic, and nursing home patients in 1986 through 1990. 2/ Because detailed specifications on including assets in income were not available, however, only veterans' incomes could be considered when estimating the proposed means test's effects.

The Means Test

Our analysis indicates that the proposed means test would reduce the population eligible for VA medical care, resulting in savings to the VA and the federal budget. Moreover, about 25 percent of veterans who would become ineligible for VA care would incur costs that would be paid under other federally supported medical programs.

The means test would probably deny eligibility to about 20 percent of all individuals who would be VA hospital or clinic patients under current law. In 1987, the first full year of implementation, about 15 percent of the expected users of VA hospital services--about 105,000 veterans, representing 158,000 hospital discharges--would be affected (see Table 1). Most VA system users who would be affected by the proposal are NSC veterans under age 65, who now use VA services by saying that they

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2. See Congressional Budget Office, Veterans Administration Health Care: Planning for Future Years (April 1984) for the methodology and the projections for 1990.

TABLE 1. THE VETERAN POPULATION AND THOSE WHO WOULD BE AFFECTED BY THE PROPOSED MEANS TEST IN 1987 (In thousands and in percent)

			Nonservice-Connected				
					Nonpensioners		
Category	Total Veterans	Service-Connected	All	Pensioners a/	Total	Less Than 65	65 or Older
Number of Veterans	28,200	3,925	24,275	680	23,600	20,670	2,930
			Current Law				
Number of Users b/							
Hospital	690	200	490	110	380	260	120
Outpatient	2,980	1,400	1,580	360	1,220	855	365
Users as a Percent of All Veterans							
Hospital	2.4	5.1	2.0	16.2	1.6	1.3	4.1
Outpatient	10.6	35.7	6.5	52.9	5.2	4.1	12.5
			Direct Impact of the Means Test's Income Provisions				
Number of Users Made Ineligible b/							
Hospital	105	0	105	0	105	75	30
Outpatient	550	0	550	0	550	425	125
Percent of Users Made Ineligible							
Hospital	15.2	0.0	21.4	0.0	27.6	28.8	25.0
Outpatient	18.5	0.0	34.8	0.0	45.1	49.7	34.2

SOURCE: Congressional Budget Office.

a. Pensioners are recipients of VA pension income. Other groups of nonservice-connected veterans are exempt from the proposal, such as World War I veterans and Vietnam veterans exposed to Agent Orange; to the extent that these groups are not counted as pensioners and service-connected veterans, they are counted as nonservice-connected nonpensioners in the table.

b. The number of veterans using services was estimated by the number of hospital discharges divided by 1.5 and the number of outpatient visits divided by 6. These utilization rates were derived from Veterans Administration staff analyses of the average number of repeat episodes per veteran served.

cannot afford medical care elsewhere, but who would not pass the proposed means test. In all, about 45 percent of the NSC clinic patients--and 28 percent of hospital patients--not exempted from the means test would lose eligibility under the proposal. 3/ Only about 25 percent of veterans losing eligibility for VA care under the means test would be age 65 or older.

If the means test were enacted, direct savings to the VA would amount to about $420 million in 1986, assuming a seven-month phase-in period, but they would be offset by higher administrative costs of almost $30 million, for net savings of about $390 million that year (see Table 2). The net savings would rise, however, to more than $1.4 billion in 1990. These estimates are based on the projected costs of VA medical care under current practices, assuming that the average costs per patient will rise because of inflation in the medical care sector, and that the number of patients will increase in proportion to the expected increases in the elderly veteran population. These projections differ from those used in the Congressional

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3. These estimates reflect the fact that some veterans who would otherwise become ineligible based on income alone would remain eligible because of their high out-of-pocket medical expenses, but it is important to note that the available data describing out-of-pocket expenditures are limited.

TABLE 2. EFFECTS ON OUTLAYS OF THE ADMINISTRATION'S VA MEDICAL-CARE PROPOSALS
(By fiscal year, in millions of dollars)

	1986	1987	1988	1989	1990
		Effects on VA Spending			
Means Test	-420	-1,030	-1,245	-1,360	-1,480
Reimbursement	-50	-130	-160	-180	-200
Administrative Costs a/	30	50	55	60	65
Total	-440	-1,110	-1,350	-1,480	-1,615
		Effects on Medicare			
HI b/	55	145	180	205	230
SMI c/	25	60	75	90	100
Total	80	205	255	295	330
		Net Budgetary Effect			
	-360	-905	-1,095	-1,185	-1,285

SOURCE: Congressional Budget Office.

NOTE: Savings, or reductions in budgetary costs, are in negative numbers. Costs are given in positive numbers. Dollars are rounded to the nearest $5 million. Details may not add to totals because of rounding.

a. Administrative costs for both proposals--the means test and reimbursement from private insurers--are included in these estimates. Only about 5 percent of the estimated increase in administrative costs would be due to the reimbursement proposal.

b. HI represents the Hospital Insurance Program (Part A) under Medicare.

c. SMI represents the Supplementary Medical Insurance program (Part B) under Medicare.

Budget Office's annual report that, to be consistent with projections for other appropriated programs, assume funding to increase only at the rate of inflation. 4/

The Reimbursement Proposal

It appears that only about 18 percent of NSC veteran patients now have sufficient private insurance coverage that the VA could recover all or part of the costs of their hospital care. This estimate is based on survey data and concurs with a recent analysis by the General Accounting Office. 5/ Our estimates also assume that few NSC veterans--roughly 11 percent--would have insurance coverage for acute psychiatric hospitalization. Moreover, because veterans with low incomes are less likely to be insured for medical expenses than those with higher incomes, only about 10 percent of the NSC veterans still served by the VA if the means test were enacted would be likely to have private coverage.

If both the means test and the reimbursement proposals were enacted, the VA could recover an estimated $50 million in 1986 from private insurers for the costs of NSC veteran patients, assuming a phase-in of the proposals. Recoveries might rise to about $200 million in 1990. If enacted without the

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4. See The Economic and Budget Outlook: Fiscal Years 1986-1990 (February 1985).

5. General Accounting Office, Legislation to Authorize VA Recoveries from Private Health Insurance Would Result in Substantantial Savings (February 1985).

means test, VA recovery from private insurers could result in revenues of roughly $160 million in 1986 and $560 million in 1990. In each case, the offset for higher administrative costs would be relatively small.

The Net Budgetary Effect

After full implementation of the proposals, about 20,000 to 30,000 former VA patients would be likely to use medical services paid for by Medicare. Almost all of these veterans would be age 65 or older. Because Medicare outlays would rise by about $200 million in 1987, and $330 million in 1990, the net budgetary effect of the Administration's VA medical-care proposals would be savings of about $360 million in 1986, increasing to $1.3 billion in 1990.

SENSITIVITY OF ESTIMATES TO CERTAIN ASSUMPTIONS

As with any projection, numerous assumptions underlie these estimates. Four are particularly important:

- Strict implementation of the means-test proposal's income provisions;
- No significant substitution of eligible hospital or clinical patients for newly ineligible ones;
- Reductions in total expenditures based on average variable costs per patient; and
- Future changes in the age distribution and economic status of VA patients that reflect historical trends.

The estimates assume strict enforcement of the income provisions under the means test by the VA. Under current law, some groups of veterans are to be served only if they are unable to pay for care elsewhere, but eligibility is determined by their unverified statements of financial ability. If a similar approach were taken to implement the Administration's proposal, the actual effects on veterans and federal outlays could be considerably smaller than estimated. On the other hand, because the Administration's proposal for taking assets into account when applying the means test has not been completely specified, its likely effects could not be reflected in the CBO's estimates. 6/ Including the value of assets in the computation of income would cause more veterans than projected to lose eligibility for VA care, however, thereby increasing federal savings.

The CBO's estimates of budgetary savings reflect different assumptions for hospital and clinical care than for nursing home care about substitution--that is, the extent to which other veterans eligible for care would replace those disqualified by the means test. The available evidence suggests that veterans eligible under current law who seek VA hospital and clinical care do, in fact, receive it; consequently, there is probably little excess demand for such care and patients excluded by the

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6. Even if the details were specified, the lack of data would make it extremely difficult to estimate the likely effects, because they would depend on the types and value of assets held by veterans.

means test would not be replaced by others. Excess capacity and underused acute-care beds are found in almost all VA hospitals today and waiting lists for VA hospital care either do not exist or are very short except at three of the 172 VA hospitals. Moreover, veterans placed on these waiting lists are eventually served. While some recently available data suggest that excess demand for clinical care may have developed in a few local areas, even substantial amounts of substitution would have only a small effect on the likely budgetary savings from the means test. 7/ For example, if the unmet demand for clinical care was 20,000 veterans per month, the CBO's estimate of savings would be reduced by 3 percent in 1987.

In contrast, long waiting lists for beds in VA-operated nursing homes exist in some local areas. Accordingly, the CBO's estimates assume that currently unserved veterans would replace most of the nursing home patients who would lose eligibility under the means test. The net result would be a decline of less than 5 percent in the VA-supported average daily census.

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7. The VA conducted a survey of its facilities in January 1984 to determine unmet demand. Although the type of care requested by veterans during the survey is not known in many cases, apparently there was excess demand for outpatient care in some areas.

To estimate the savings from each patient denied care under the means test, measures of the average variable cost per patient were developed for each of the three types of service. Major construction and educational costs were assumed to be fixed--that is, they would not change in response to a declining patient census--and therefore were not included in the estimates. Costs for VA medical personnel, supplies and equipment, minor construction, and maintenance and repair were assumed to be variable--that is, they could all be reduced in proportion to a fall in the patient load. This variable cost assumption might lead to an overstatement of the savings, especially in the short run as specialized positions or resources might not be eliminated in sufficient numbers. In the longer run, however, the VA might find opportunities for disproportionately larger savings. For example, in response to the smaller patient loads under the means test, either currently underused facilities could be closed or planned construction might be eliminated.

A final set of assumptions was necessary because available administrative data contain insufficient information about veterans' financial status. The VA collects neither income nor insurance information from NSC veterans currently served at its medical centers; the only income-related information is a count of who is receiving a VA pension. As a result, CBO had to combine survey information on the economic situation of users of the

VA health care system with administrative data.[8] As on any survey, income is likely to be underreported. Such underreporting would also cause our savings estimates to be too low.

In sum, although certain assumptions would cause the estimated budgetary effects of the Administration's proposed means test to be overstated, others would lead to underestimates. For example, incomplete implementation of the means test could substantially reduce savings, but considerably greater savings would accrue if veterans' assets were reflected in the eligibility determination.

CONCLUSION

Although it is difficult to estimate precisely the impacts of the Administration's proposals, they would reduce eligibility for VA medical care and result in budgetary savings. Under the proposed means test, about 20 percent of veterans currently using VA hospitals or clinics would no longer be allowed to do so, and few, if any, other veterans would be substituted for them. In contrast, because of lengthy waiting lists for nursing home care in many localities, the average daily census of VA nursing home patients is estimated to decline by less than 5 percent. By 1990, the proposed means test would save about $1.4 billion in VA spending for health care, and an accompanying private insurance reimbursement proposal would save about $200 million. After accounting for added Medicare outlays, the net budgetary savings from these proposals would be roughly $1.3 billion that year.

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8. The following surveys were used in this analysis: 1979 Survey of Veterans (Veterans Administration); Survey of Aging Veterans (Veterans Administration; Lou Harris, 1983); and National Medical Care Expenditure Survey (tabulations provided by the National Center for Health Services Research and Health Care Technology Assessment).

RESPONSE OF THE CONGRESSIONAL BUDGET OFFICE TO WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. During questioning at the hearing you provided savings projections based on a modified version of the Administration's means test proposal, assuming an income and asset ceiling of $25,000, no spend down provision, and an implementation date of October 1, 1985. Please restate your estimate of the potential savings which could be achieved, taking into account the effect of any offsetting factors such as administrative costs and the impact on Medicare.

Answer 1A. Such a variation in the means-test proposal would probably affect fewer nonservice-connected (NSC) veterans and save the federal government less in VA medical expenditures than would the Administration's proposal. If enacted and implemented by October 1, 1985, the net federal savings in 1986 would be $365 million, rising to $530 million in 1990. These estimates would be about 50 percent of the projected net savings under the Administration's proposal. Because the VA has testified that a minimum of 90 days would be required to implement a means test, an October 1, 1985 implementation date is no longer possible. Thus, the full $365 million in savings could not be realized in 1986.

Please note that the estimates described by Dr. Gordon during the hearing were for the modified means-test proposal with a spend-down provision. In addition, they assumed that the means test would not be fully implemented until seven months after an enactment date of October 1, 1985.

Question 1B. Please also include in your reply:

(1) the impact on veterans' access to health care; and

(2) the impact on the number of VA employees and resources.

Answer 1B. The modified proposal would cause about 12 percent of currently served VA patients to lose eligibility for VA care. This would mean that about 46,000 fewer hospital patients and 313,000 fewer clinic patients would be served by the VA in 1986 than would be served under current law.

Given the projected distribution of VA medical expenditures in 1987, the likely impact of the modified means-test proposal on the number of VA employees (full-time equivalent employees or F.T.E.E.) and VA resources would be as shown below:

	Expenditure Reductions in 1987 (In millions of dollars)	Staff Reductions in 1987 (F.T.E.E.)
Employee Salaries and Fringe Benefits	315	10,500
Supplies, Equipment, and Other Resources	210	NA
Total	525	10,500

If the reductions in personnel and resources were more or less equally distributed across local areas, and reductions were proportional to the reduced demand for care, the proposal would have little impact on veterans' access to health care beyond the reductions in eligibility. In addition, only about $31,500 would be cut from funds for the maintenance and repair of facilities. Thus, there would be little impact on the size or condition of VA medical centers.

The impact, however, might be disproportionately felt in a few geographical areas where veterans' incomes are higher than the national average, such as in some areas in the Northeast and North Central regions. In this case, demand for some services provided in VA facilities that are currently underused might fall enough that some sections of those facilities would be closed, possibly reducing access for veterans who would remain eligible.

Question 1C. If a copayment provision was added to the modified means-test proposal to allow certain veterans with income above $25,000 to receive VA health care, what impact would this provision have on potential savings and offsetting factors?

Answer 1C. By requiring copayments instead of denying VA care under the modified proposal, net federal savings would be about $30 million in 1986, rising to $60 million in 1990. This small budgetary effect reflects the proposal's provisions concerning the deductible and coinsurance amounts to be paid by nonservice-connected veterans with incomes above $25,000; the copayments represent a small portion of the total costs of care. The estimates also reflect potential Medicare offsets of about $16 million in 1986 and $29 million in 1990.

The copayment provisions assumed for the proposal are similar to those under the Medicare program, but with some important exceptions. Our main assumptions about the proposed copayments are:

- For hospital care, the Medicare deductible--anticipated at $476 in fiscal year 1986--would be charged. After the first 60 days, coinsurance equal to 25 percent of the deductible would be charged for each day up to the 90th day. Unlike Medicare, this option would require no further coinsurance after the 90th day of hospitalization.

- Under this option, no coinsurance would be charged for outpatient care required in connection with a VA hospital stay. For all other outpatient visits, coinsurance equal to 20 percent of the cost of care would be required, but no annual deductible payment would be made.

- A deductible equivalent to the VA's cost for one day's care would be charged for nursing home care. It was assumed that the deductible would be specific to the cost of VA-supported care in the different types of nursing homes--that is, in VA, community, or State homes.

- Copayments would not be charged by the VA in those cases where the cost of care would be fully reimbursed through combined payments from veterans and their private insurance companies under the terms of the insurance policies.

Question 1D. How would the potential savings from this modified means-test proposal be affected by implementation of the Administration's third-party reimbursement proposal?

Answer 1D. By adding third-party reimbursement to the modified means-test proposal--that is, assuming an income cutoff level of $25,000 for a veteran with one dependent--net federal savings would increase by over 50 percent. The net budgetary effect would be a reduction of $540 million in 1986 outlays, assuming an October 1, 1985 implementation schedule. Outlay savings would rise to $820 million in 1990.

Question 2. You stated in your most recent estimate that 70% of nonpension elderly nonservice-connected veterans are eligible for Medicare. Of the remaining 30%, how many do you estimate would be denied VA health care under the Administration's means test? What percentage of this (30%) group would be covered by private health insurance?

Answer 2. Of the 30 percent of nonpension, elderly NSC VA patients who may not have Medicare coverage today, we estimate that about five percent of them could be denied VA care under the proposed means test; about 60 percent to 80 percent of the elderly NSC veterans would have private insurance coverage. Practically all of those veterans made ineligible for VA care under the proposed means test, however, would be likely to have some health insurance coverage, because veterans and other persons with higher incomes usually are covered. Our estimates are based on survey data, however, and it is difficult to determine the adequacy of the policies held by privately insured veterans.

RESPONSE OF THE CONGRESSIONAL BUDGET OFFICE TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. **On page 4 of your statement, you note that "about 25 percent of veterans who would become ineligible for VA care (as a result of a means test) would incur costs that would be paid under other federally supported medical programs." How, according to your analysis, would payment for care for the remaining 75 percent be made?**

Answer 1. Most nonservice-connected veterans who would be affected by the proposed means test would be nonelderly veterans with private insurance coverage or who would have the ability to pay for private medical care. Although our estimates of the impact of the means test on federal costs do not explicitly include any estimates of the distributions of different nonfederal costs, it is likely that 95 percent of veterans made ineligible by the means test would incur costs for their hospital care that would be paid, partially or in full, by private insurers.

Question 2. **What would be the impact on your estimate of the number of nonservice-connected veterans who would be denied care if the income threshold for a veteran with one dependent were raised to $20,000 and what would be the impact if the threshold were raised to $25,000?**

Answer 2. If the Administration's proposal were modified by raising the income-eligibility limit to $20,000 for a nonservice-connected veteran with one dependent, about 40 percent fewer VA hospital patients and 20 percent fewer clinical care patients would lose eligibility for VA care than the number who would lose eligibility under the Administration's proposal. The impact of changing the income cutoff to $25,000 would be to eliminate eligibility for about one-third as many hospital patients and one-half as many clinic patients as under the Administration's proposed means test. For example, in 1987, 34,000 hospital and 280,000 clinic patients would lose eligibility under the proposal with a $25,000 threshold, compared with the 106,000 hospital patients and 551,000 clinic patients who would be denied VA care under the means test proposed by the Administration.

These projected impacts are shown in the following table.

TABLE 1. THE NUMBER OF NONSERVICE-CONNECTED VETERANS AFFECTED BY DIFFERENT MEANS-TEST PROPOSALS, BY TYPE OF CARE FOR FISCAL YEARS 1986-1990

Type of Service	1986a/	1987	1988	1989	1990
Administration's Means Test Proposal					
Hospital Care	41,300	105,700	107,200	108,600	109,700
Outpatient Care	217,900	550,600	556,400	562,100	567,900
Nursing Home Care	400	1,000	1,100	1,200	1,200
Total	259,600	657,300	664,700	671,900	678,800
$20,000 Income Cutoff Level					
Hospital Care	25,100	64,100	65,100	66,000	66,600
Outpatient Care	174,400	440,500	445,100	449,700	454,300
Nursing Home Care	200	600	600	700	700
Total	199,700	505,200	510,800	516,400	521,600
$25,000 Income Cutoff Level					
Hospital Care	13,300	34,000	34,500	34,900	35,300
Outpatient Care	111,400	281,400	284,400	287,300	290,300
Nursing Home Care	100	300	300	300	400
Total	124,800	315,700	319,200	322,500	326,000

SOURCE: Congressional Budget Office.

NOTE: Numbers may not sum to totals due to rounding.

a. The estimates for 1986 reflect an assumed seven-month phase-in period before the proposals could be fully implemented.

Question 3. **On page 6 of your statement, you indicate that, if a means test were enacted, "savings to the VA would amount to about $420 million in 1986...(and) to more than $1.4 billion in 1990."**

a. What do you estimate would be the F.T.E.E. reductions associated with those "savings" in each of the fiscal years 1986 through 1990?

b. How many fewer inpatient episodes of care and outpatient visits would those savings reflect?

Answer 3. The probable reductions in full-time equivalent employment (F.T.E.E.) caused by the Administration's proposed means test would represent about 11 percent of the projected F.T.E.E. under current law. One must be careful in interpreting this impact, however. For example, one can assume that the employment level would fall by about 21,000 in the first full year of implementation. But in future years the reduction in F.T.E.E. would be the same 21,000 plus some additional reductions that would be based on the increases in medical staff and other personnel expected under current law.

The reductions in inpatient episodes of care and outpatient visits associated with the CBO's estimates of VA savings under the proposed means test are shown in Table 2.

TABLE 2. EPISODES OF CARE ELIMINATED UNDER THE ADMINISTRATION'S PROPOSED MEANS TEST (By fiscal years, in thousands)

Type of Care	1986	1987	1988	1989	1990
Hospital	62	159	161	163	165
Outpatient	1,307	3,304	3,338	3,373	3,407
Nursing Home	a/	1	1	1	1

SOURCE: Congressional Budget Office.

NOTE: Numbers are rounded to the nearest one thousand.

a. Less than 500 veterans would be in this category.

Question 4. **Is it your position that, if the means test were enacted, the VA's regular FY 86 appropriation should be reduced by about $400 million so that even if your estimate of cost-savings is too high, savings in that amount would nevertheless be realized?**

Answer 4. The Congressional Budget Office is a nonpartisan organization that does not advocate any specific policy option or budget action by the Congress.

Question 5. **With reference to the issue of the current demands for VA care, discussed on pages 10 and 11 of your statement, is there any material that would provide information on this issue that you have requested from the VA but not yet received?**

Answer 5. We have requested that the VA provide information about the type of care requested by applicants for VA care during the VA's January 1984 survey of facilities. It is now our understanding that such information was captured explicitly only on the questionnaires for the telephone requests, and that type-of-care information for walk-in and mail-in applicants will not be available until future surveys.

Question 6. **On page 6 of your testimony, you state that the cost-savings you are presenting for the means test "are based on the projected costs of VA medical care under current practices, assuming that the average cost per patient will rise because inflation in the medical care sector..." On pages 6 and 8, however, you state, "these projects differ from those used in the Congressional Budget Office's annual report that...assume findings to increase only at the rate of inflation."**

A. **In an official CBO cost estimate, which inflation factor would be used?**

B. **Please state (i) what have been the annual rates of inflation experienced by the VA during each of the fiscal years 1979 through 1984 in the cost per hospital inpatient episode of care and per month of nursing home care, in VA facilities, and (ii) the rates of inflation you used for VA hospital and nursing home care for purposes of the means test cost-savings estimates.**

Answer 6A. Estimates of the impact of the Administration's proposals based on the CBO baseline (used for the annual report) and the most recent projections of the impact based on additional growth in the number of veterans eligible for VA care under current law differ only in the out years--that is, 1989 and 1990--of the projection period. An official CBO estimate of the proposals' impact would use the set of inflation factors that assume growth in the user population as well as some inflation in the medical-care sector.

Answer 6B. The average costs you have requested are given in the table below.

TABLE 3. AVERAGE COSTS PER PATIENT TREATED IN VA FACILITIES AND PERIODIC GROWTH RATES, FISCAL YEARS 1979-1984 (In dollars and percent)

	Average Costs Per Patient[a]			Growth Rates[b]		
	Hospital	Nursing Home (Annual)	Nursing Home (Monthly)	Hospital	Nursing Home (Annual)	Nursing Home (Monthly)
1979	2,772	15,140	1,995.76			
1980	3,077	17,169	2,291.86	11.0	3.4	14.8
1981	3,222	17,730	2,457.54	4.7	3.3	7.2
1982	3,629	18,738	2,771.57	12.6	5.7	12.8
1983	3,833	19,210	2,979.20	5.6	2.5	7.5
1984	3,947	20,806	3,278.34	3.0	8.3	10.0
Average Annual Growth				7.4	6.6	10.4

SOURCE: Congressional Budget Office; Office of Management and Budget, Budget of the United States Government, FY 1986, Appendix.

a. The average costs per patient are computed by dividing the number of patients treated during the fiscal year into the total costs incurred by the VA for the specific types of medical care.

Monthly costs for nursing home care were divided by multiplying the average per diem (per patient) rate times 30.4 days.

b. Growth rates represent the year-to-year increases in the average per patient costs, except that the monthly nursing home rates reflect changes in the monthly costs.

The projected medical-care inflation rate was used for both the CBO hospital and nursing home estimates of savings for 1986 through 1990. These rates are shown below.

	1986	1987	1988	1989	1990
Percent Increase in Per Patient Costs	6.65	7.06	7.50	7.75	7.78

Question 7. **On page 7 of your testimony, you indicate that, if the VA means test were implemented, Medicare outlays would rise a total of $540 million in fiscal years 1986 through 1988. The Senate Republican Leadership has indicated that the totals for function 700, Veterans' Benefits and Services, in the FY 86 Budget Resolution as passed by the Senate on May 9, are based on enactment of a health-care means test.**

A. **(i) Do the totals for function 570, Medicare, in the Senate-passed resolution include any increases attributable to the assumption regarding the VA health-care means test?**

(ii) (If yes) In what amounts were the function 570 totals increased for each year of FY's 86, 87, and 88?

(iii) (If no) If you can, please state why not.

B. **In each of FY's 86, 87, and 88, what would be the average Medicare copayment and deductible per episode of care for each veteran who is denied VA care as a result of the means test and who uses Medicare benefits for the care involved?**

Answer 7A. The CBO did not prepare the savings estimate attributed to a VA health-care means test in Senate Concurrent Resolution 32. Since the Senate Budget Committee has not yet published any details of the proposal or of its treatment in the Senate-passed budget resolution, the CBO is unable to provide the answers to these questions at this time.

Answer 7B. The CBO estimates of the deductible and copayment amounts to be paid by Medicare beneficiaries under current law, for hospital, nursing home, and outpatient care, are shown for the next three fiscal years in Table 4.

TABLE 4. PROJECTED DEDUCTIBLE AND COPAYMENT AMOUNTS TO BE PAID BY MEDICARE BENEFICIARIES BY TYPE OF MEDICAL SERVICE AND PAYMENT (In dollars, by fiscal years)

Type of Service and Payment	1986	1987	1988
Hospital Care			
Deductible	476	524	544
Copayment (per day 61-90)	119	131	136
Copayment (per reserve day 91-150)	238	262	272
Nursing Home Care			
Copayment (per day 21-100)	59	65	68
Outpatient Care			
Deductible	75	75	75
Copayment (per visit) a/	10	11	12

SOURCE: Congressional Budget Office.

a. Data are not available to assess adequately the average cost per outpatient visit paid by Medicare beneficiaries. The copayment per outpatient visit is based on the costs to the VA for outpatient medical care given to veterans in the private sector and paid for by contract or on a fee basis; it represents 20 percent of the average invoice cost per visit.

Question 8. **On page 11 of your testimony, you note that "if the unmet demand for clinical care was 20,000 veterans per month, the CBO's estimate of savings would be reduced by 3 percent in 1987." However, in response to a question from Chairman Murkowski during the Hearing, you stated that the reduction in CBO's estimate would be 20 percent. Please clarify this point.**

Answer 8. During the hearing, we described the maximum impact of serving the 20,000 eligible veterans that the VA believes are denied care under current law. The 20-percent offset from VA savings could occur if one assumes that 20,000 veterans per month would require different types of VA care in the same proportions as those currently served; this assumption was made because data describing unmet demand by type of care were unavailable. If, on the other hand, only clinical care were demanded by the 20,000 veterans--a likely situation according to some VA documents--the offsetting cost impact would be 3 percent of the projected VA savings.

Chairman **Murkowski**. We will move to the next panel which is the health insurers. These witnesses are prepared to reflect on the appropriateness of the question at hand, which is third party reimbursement. The question that I would like to have you reflect on is the official position of the insurance companies and the various underwriters with regard to, what I understand is a significant portion of the population covered under health insurance, either voluntary or required, and that the employer takes a tax deduction for the withholding for coverage, yet the coverage is never called upon in the case of a veteran employee who receives care at a VA medical center. I am curious to know how the insurance company carries that actuarily on their financial statements because it is coverage that they are precluded from paying under law, yet they collect for it from employers and veteran employees. It seems a bit unusual that we find that we have situations like this where the private sector can basically take in payment without having the services rendered.

Please proceed.

TESTIMONY OF A PANEL OF HEALTH INSURANCE REPRESENTATIVES CONSISTING OF: MARY NELL LEHNHARD, VICE PRESIDENT, OFFICE OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC; AND PHILIP BRIGGS, EXECUTIVE VICE PRESIDENT, METROPOLITAN LIFE INSURANCE CO., AND REPRESENTATIVE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Ms. **Lehnhard**. Would you like me to go through our statement or respond to your——

Chairman **Murkowski**. Well, it is 20 minutes to 12 now. I would appreciate if you have a statement, highlighting the points that you would like to make. The rest would be entered into the record.

Ms. **Lehnhard**. I would be glad to highlight my statement then respond to your point.

Mr. Chairman, I am Mary Nell Lehnhard, vice president for the Blue Cross and Blue Shield Association. We are the coordinating agency for all the individual Blue Cross and Blue Shield plans.

I would like to respond first off to your point about our insurance companies reaping windfall profits. And our response——

Chairman **Murkowski**. We usually use that for the oil companies, but they would be happy to see somebody out there to share that exposure with.

Ms. **Lehnhard**. Our response to that is the same response we have had all along, and it is that we are definitely not reaping any kind of windfall profit.

Chairman **Murkowski**. What do you do with that profit?

Ms. **Lehnhard**. I would explain that the premiums or the cost of an insured group are based on payments that we make in behalf of that group, actual money that we pay out when they incur services. In this case we are not paying for services when employees of a major or small employer go to a VA facility. So those costs are not reflected in that group.

Chairman **Murkowski**. But you are collecting premiums from them though?

Ms. LEHNHARD. Yes. That is the second point. In most cases now employers will pay the full cost of a premium. Where the employer does ask his employee to pay a part of the premium, say 10 percent, that employee nearly always has the right to refuse that policy.

For example, if he decides he wants to get all his care from a VA facility he will quite wisely decide not to take that employer's insurance policy; he does not have to pay the 10 percent. However, he might decide that he wants to pay that 10 percent to insure against his having to go to a specialist out in the community.

And that 10 percent, I would go back, is not a windfall. We do not put it on a shelf anywhere and save it. It reflects the actual usage of that group, including that veteran going out to a community hospital.

Chairman MURKOWSKI. So you collect it, and you just put it in your actuarial as part of the group exposure, so to speak. It basically cuts down the cost, theoretically, to those who are participants in the plan that do not use a VA facility, but use the private sector facility. So the Federal Government——

Ms. LEHNHARD. It would reduce——

Chairman MURKOWSKI [continuing]. In effect is kind of subsidizing?

Ms. LEHNHARD. It would reduce the overall cost to the employees in that group.

Chairman MURKOWSKI. Yes.

Ms. LEHNHARD. It also reduces the cost if the veteran is sharing in that premium, it reduces his cost. And I would also point out that it reduces the cost for an employer who hires a large number of veterans.

Chairman MURKOWSKI. So basically the employer takes the deduction, which the employer has a right to do. Concerning the veteran, depending on what type of policy the veteran has, whether it is a voluntary withholding or an option, whether the veteran partially pays or whether the employer pays it all, that is reflected in the grouping-type policy and coverage that you have out there?

Ms. LEHNHARD. With respect to your point about taking a deduction, the employer is not taking a deduction which reflects anything the VA is paying.

Chairman MURKOWSKI. That's right.

Ms. LEHNHARD. It is only expenses he is actually paying for all of his employees, including those veterans that go to community hospitals.

Chairman MURKOWSKI. You have heard the discussion with regard to the position of the VA and the Justice Department on the constitutionality issue. Their opinions express the belief that the Federal Government would have the right under the change of law that would be necessary, to provide the administrative changes, so that a reimbursement could come into the VA system for health-care received.

Is it the intention of the health-care group that you represent to litigate?

Ms. LEHNHARD. I cannot say at this point whether we would litigate or not. I think if this law were to pass we would have to look at our legal findings, consult with our outside counsel. And as a matter of fact, each of our 90 Blue Cross and Blue Shield plans would make up, probably, their own mind individually, separate from each other. They are independent plans.

Chairman **Murkowski**. Would you anticipate having to raise your costs because of it?

Ms. **Lehnhard**. The employers' premiums, employers who hire veterans, their premiums would definitely go up. If you are speaking of the costs of litigation, I am not——

Chairman **Murkowski**. No; I am not speaking of the costs——

Ms. **Lehnhard**. I am not free to say whether we would sue at this point or not.

We do believe and continue to believe that there is a constitutional question.

Chairman **Murkowski**. Well, yes. As long as you have more than one attorney around, you are going to have somebody willing to take that question up.

[The prepared statement of Mary Nell Lehnhard, vice president, office of government relations, Blue Cross and Blue Shield Association, Washington, DC, follows:]

PREPARED STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, OFFICE OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. Chairman and members of the committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. Our Association is the coordinating organization for the nation's Blue Cross and Blue Shield Plans. Through these Plans, private and public health insurance benefits are provided to some 100 million people. We appreciate this opportunity to present our views concerning the Veterans Administration (VA) Fiscal Year 1986 budget proposal to require available private insurance to pay for care provided in VA medical facilities to veterans with non-service-connected conditions.

We strongly oppose VA's proposal for the following reasons:

1) It violates the principle of insurance;
2) It violates the protection of the Fifth Amendment of the Constitution; and
3) It shifts to the private sector — primarily employers — a new set of financial obligations without the safeguards needed to contain health care cost increases.

Before addressing our concerns in more detail, it is important to review briefly how insurance premiums are established, and what effect this new policy would have on them. We want to correct any misconception that insurance companies have been reaping "windfall profits" by not reimbursing for care provided in VA hospitals; that allegation is simply not true. The premiums or costs of an insured group of individuals are based on actual payment for services that are covered and used by the group. Insurance contracts specifically exclude payment for services for which there is no charge, such as those provided in government-owned facilities like veterans hospitals.

Because payment cannot be made for these free services, their cost is not reflected in the group's premium. Simply put, we do not charge premiums for benefits we do not provide. Accordingly, if insurers were required to pay for care provided in VA facilities, premiums would rise.

Violates the Principle of Insurance

The purpose of insurance is to protect a subscriber against a loss. Under the terms of insurance contracts, there will be no benefits payable for care for which the insured has no obligation to pay. The care VA facilities provide to veterans is furnished to them without charge, thus these individuals suffer no loss. To require payment for this free care violates the most basic principle of insurance contracts.

Violates the Fifth Amendment

Because of the absence of any financial liability on the part of veterans using a VA facility, we believe that the proposal would violate the guarantees of the Fifth Amendment of the Constitution. The Fifth Amendment requires that no private property be taken for public use without just compensation, unless there is a real threat to the health and safety of the community at large. Clearly, there is no threat to health and safety that has brought about VA's proposal. Rather, the VA is seeking to take substantial amounts of private funds to offset its own financial obligation — the provision of health care to veterans. Whether the loss of these funds can be offset by increased insurance premiums is immaterial to the legality of taking them without compensation.

The Constitution protects against this kind of overreaching by government to support its operations. A detailed analysis of the unconstitutionality of VA's proposal prepared by Miller and Chevalier, Chartered, a Washington law firm, is attached to our statement.

Shifts Federal Costs to the Private Sector without any Controls

The clear effect of this initiative is to transfer some of the financial obligation for health care services furnished to veterans with non-service-connected illnesses in VA facilities from the government to the private sector - primarily to those who employ veterans. The businesses hardest hit would be those who employ many veterans (especially older veterans who use more care), those located in areas with a high availability of VA beds, and certain low-wage employers whose workers may be more inclined to seek free care in a VA facility than private care subject to the cost-sharing requirements of their private health plan. However, even the employers most dramatically affected by VA's proposal would have no control over the new costs.

In response to the need to control costs, the private sector has become extremely involved with how health care services are financed as well as how they are delivered. Through Blue Cross and Blue Shield Plans and other insurers, and on their own for those who self-fund, employers are placing controls on all aspects of the health care services they finance. For example, screens and limits have been established to help reduce hospital lengths of stay. These parameters are not arbitrary limits, but represent concerted efforts between the payer and the hospital to establish more cost-effective patterns of care. Hospitals themselves are subject to local health planning requirements that seek to avoid unnecessary capital expenditures, and undergo rigorous medical and financial audits - all to assure private control over health care expenditures.

However, because hospital care is the most expensive component of health care costs, the most dollars are saved by avoiding hospitalization where appropriate. This is done most successfully through programs such as mandatory preadmission review, requiring outpatient care wherever possible, and mandatory second opinions for elective surgery. If patients do not follow these requirements, they are at greater financial risk. We understand that such financial incentives for patients would be prohibited under the VA proposal. In addition, these programs require close coordination among the patient, the provider and the payer, which would be difficult in the VA system.

A number of employers also have achieved cost savings by offering health maintenance organizations - HMOs - or by establishing financial incentives for their employees to use designated hospitals and physicians in the community that have agreed to provide health care services for a lower price or with more stringent utilization controls. These new arrangements are called Preferred Provider Organizations — PPOs — and have demonstrated significant savings. Other employers, again through their insurer or on their own, are contracting with the most cost-effective providers in the community. Individuals covered under this kind of arrangement are not reimbursed for their medical expenses if they go to providers not designated under their employers' contract. This "selective contracting" is the end result of marketplace competition - competition that VA hospitals have not participated in and probably could not succeed in.

The private sector also increasingly relies on the use of deductibles and copayments to deter unnecessary utilization. These out-of-pocket costs give the patient a reason to participate in the decisions on his or her health care, and have been established as reasonable cost containment activities. The selective application of cost-sharing also reinforces programs such as the mandatory preadmission review for hospital care mentioned earlier. VA's proposal, as we understand it, would not require non-service-connected veterans to participate in such cost sharing. We believe this approach does not provide for adequate private sector controls on utilization of VA health care facilities.

Blue Cross and Blue Shield Plans have been leaders in establishing effective cost controls. Plans contract not only with their subscribers, but also with health care providers. Participating hospitals agree to furnish services to our subscribers under terms specified in the contract. These terms are designed to assure patients of appropriate, high quality health care at reasonable costs. While the contract terms vary from community to community to meet local needs, they typically call for member hospitals to participate in areawide health planning processes, and medical and financial review activities.

We believe these and other requirements are critical to assuring adequate control over employers' health care dollars. We do not believe that VA facilities are prepared to deal with insurers and employers at this level. And, we doubt their capacity to do so. Looking only at the issue of financial audits, we know that VA hospitals have never undergone the level and type of audit performed by private insurers in community hospitals, and we question their ability to do so. Even if the VA could meet private sector requirements, it would not be without a substantial cost, in our opinion. Certainly, these costs need to be considered when reviewing VA's proposal.

We also must note here that VA's proposal for its health care program is totally inconsistent with the philosophy of Medicare, the federal health insurance program for the elderly and the disabled. Many of the private sector efforts to control health care costs are replicated in Medicare. The government demands that everything possible be done to control both the price and the utilization of the health care services purchased for Medicare beneficiaries. The Veterans Administration is a part of that same government, yet with their proposal VA is saying that the private sector must purchase care without the checks and balances under which the government purchases care. Surely Congress would not wish to send such conflicting signals.

Finally, we believe that the recent report of the General Accounting Office, which recommended legislation to authorize VA recoveries from private insurance, is seriously flawed. Our detailed comments on the report are attached.

Conclusion

In conclusion, we ask that you deny the Veterans Administration's request for the authority to require payment from private insurance for care provided in VA hospitals. We do so because we believe that this initiative is not consistent with the principle of insurance, violates the protections of the Constitution, and shifts federal obligations to the private sector without the safeguards to control escalating health care costs.

Attachments

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April 8, 1985

Ms. Mary Nell Lehnhard
Vice President, Government Relations
Blue Cross and Blue Shield Association
1709 New York Avenue, NW
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Payment for Care in VA Facilities

Dear Ms. Lehnhard:

This is in response to your request for legal analysis of the proposal set forth in a report issued by the General Accounting Office entitled, "Legislation To Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings."

By coincidence, at your request, we recently have completed research and analysis into the constitutionality of a similar proposal by the Defense Department. Our conclusion was that the DOD proposal is unconstitutional because it represents a taking of property for government use without just compensation in violation of the Fifth Amendment. For the reasons set forth below, we reach the same conclusion with respect to the GAO proposal. Because we believe the GAO report deals with peripheral issues only and skirts this central constitutional issue, we will set forth our analysis in some detail.

BACKGROUND

By law, the United States provides free medical care to certain veterans in hospitals operated by the Veterans Administration. Some of these veterans are covered by their employer's health insurance or self-insured health benefits plans. Typically, under the terms of the insurance contracts between the corporate employer and the insurer and the terms of the self-insured plans, the employee-subscribers will not receive benefits for care provided in a governmental hospital or for any care received without charge.

The limitations on payment of benefits for care rendered in governmental hospitals are a reflection of a basic principle of insurance -- insurance only indemnifies an insured for a loss which the insured has incurred. 1 G. Couch, COUCH ON INSURANCE 2D § 1:9, at 15-16 (rev. ed. 1984). Because the employee-subscribers are not required to pay the government for the care provided to them in VA hospitals, they have not incurred a loss which can be indemnified by their insurers or the self-insured plans. Benefits would not be payable, even if the contracts did not contain specific exclusions, because the care is rendered free to the veterans and is not a compensable event.

The insurers and self-insurers have used two types of exclusions, however, to make it clear that benefits are not payable for free care. One exclusion provides, generally, that benefits never are payable for care for which the insured is under no legal obligation to pay in the absence of insurance. This applies to various types of free care, including free care provided by relatives, state hospitals, military hospitals, etc. The other exclusion states that benefits are not payable for care provided by any governmental unit. The latter type of exclusion has grown out of the fact that governmental hospitals do not charge for care rendered to eligible patients.

The effect of these exclusions is reflected in the premiums charged by insurers. Because the premium reflects the experience of the entire group's costs in previous years, premiums are lower because care in veterans' hospitals has not been compensated. (The administration has acknowledged this. S. Rep. No. 79, 97th Cong., 1st. Sess. 113, 1981 U.S. Code Cong. and Ad. News 1685, 2551.)

The premium rate for each member of the employee group is the average cost of the health benefits for all group members. Many insureds will not receive any benefits, because they are not sick, and others will receive benefits far in excess of the premium because they are very ill. This spreading of risk among all members of the group is the essence of insurance. Group Life and Health Insurance Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979) (quoting 1 G. Couch, CYCLOPEDIA OF INSURANCE LAW § 1:3 (2d ed. 1959)).

The GAO is proposing that Congress should require insurers and self-funded plans to pay the federal government for care the VA provides free of charge to certain veterans. This legislation would void the contract exclusions in group insurance contracts which exclude benefits for free care insofar as they apply to veterans' hospitals.[1] The purpose of this legislation is to transfer, according to GAO's estimate, approximately $100 million from private insurance and self-insured plans to the government to reduce the government's expenditures for care of veterans in VA hospitals.

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[1] The GAO proposal does not distinguish between group insurance provided (and largely paid for) by employers and individual policies of insurance purchased by individuals. Because most insurance today is sold as group policies, for purposes of this discussion we will assume the proposal relates only to group insurance.

ISSUE

The issue is whether Congress has the authority under the Constitution to require insurers and self-funded companies, in order to reduce the federal government's expenditures, to pay for care rendered in VA facilities to veterans who are entitled by statute to free care provided by the government.

DISCUSSION

The Fifth Amendment of the Constitution of the United States requires that no "private property be taken for public use, without just compensation." The purpose of the Amendment is to "bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." Armstrong v. United States, 364 U.S. 40, 49 (1960). The clause was designed to prevent the "arbitrary use of governmental power" to exact "forced contributions" to the government. Webb's Fabulous Pharmacies Inc. v. Beckwith, 449 U.S. 155, 164 (1980).

1. The Government Cannot Take Property Without Compensation In The Conduct Of Its Own Enterprises.

The Supreme Court has recognized that the principles of justice and fairness in the Fifth Amendment require that the government must pay for intrusions on property rights when the government is appropriating property for its own use to enable it to operate one of its governmental functions, or one of its "enterprises."

In its earliest considerations of the Fifth Amendment, the Supreme Court drew a line between governmental intrusions on property rights which were a "taking" of property under the Fifth Amendment, which required compensation, and those intrusions which were "a mere incident of the lawful exercise of the 'police power,' and thus (were) not compensable." Sax, *Takings And The Police Power*, 74 Yale L.J. 36 (1964). The Court recognized that justice and fairness required that certain types of economic injuries caused by public action were to be compensated: when the government sought to erect a post office on Jones' land, it was obvious that the government had to pay Jones for the property. See *Pumpelly* v. *Green Bay Company*, 80 U.S. (13 Wall.) 166 (1871). In other situations, the Court recognized that compensation was not due: when the government sought to close down Mugler's brewery because it was considered a nuisance, the government did not have to pay for the brewery. *Mugler* v. *Kansas*, 123 U.S. 623 (1887).

That dichotomy between a taking of property and an exercise of the police power exists to this day. The government (the state under its police power and the federal government under the Interstate Commerce Clause) regulates the use of property in myriad ways, from zoning laws to regulation of toxic wastes.[1] These intrusions on private property have been largely uncompensated, because they resulted from valid exercises of the government's police power to protect the health, safety and welfare of the larger community.[2]

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[1] The essential aspect of the police power cases is a recognition that there are certain regulatory restrictions

These police power cases must be contrasted with situations in which the government intrudes on property interests while carrying out its own operations. In the latter situation, the government is functioning in its "enterprise capacity." Sax, supra at 62; Penn Central Transp. Co. v. New York City, 438 U.S. 104, 135 (1978). When the government intrudes on private interests in its enterprise capacity, it must pay.

The government acts in an enterprise capacity when it does such things as operate a post office or build roads and dams. In carrying out these functions, the government

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on property which must be borne. "There must be progress, and if in its march private interests are in the way, they must yield to the good of the community," Hadacheck v. Sebastian, 239 U.S. 394, 410 (1915). The Court has recognized that to govern, the government must mediate between conflicting and competing values; when private parties are at odds, the government must decide which one will be the winner and which the loser. Sax, supra at 62-63. Thus, when the interests of an owner of a brick yard and the neighboring residents conflict, the government may enact a zoning law and require the owner to shut down his yard and no compensation is required. Hadacheck, 239 U.S. 394; see also Goldblatt v. Hempstead, 369 U.S. 590 (1962).

[2] Even when the government is exercising its police power, the courts have sometimes found that the regulation goes too far, and the interests of fairness require compensation. Goldblatt, 369 U.S. at 594 (citing Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 415 (1922)).

operates very much like a private business. It must have resources to operate: land, buildings, and funds. Sax, supra at 62. Of course, the government's "enterprises" include governmental functions which have no private counterpart, such as maintaining an army.

When the government acquires or uses private property in the operation of its enterprises, the courts have recognized that fairness and justice dictate that the government must pay like any other business. Thus, the government could not obtain a school yard by zoning a business property solely for use as a school yard; it must purchase the property for that use. Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 415 (1922).

Several Supreme Court cases demonstrate the obligations of the government as enterpriser. As the Supreme Court has recently pointed out, a classic example of the government acting in its "enterprise capacity" is the case of United States v. Causby. Penn Central, 438 U.S. at 135. In Causby, the federal government established a military airport next to Causby's chicken farm, and the low-flying airplanes destroyed the utility of the farm. The Supreme Court decided the government had to pay for the property. United States v. Causby, 328 U.S. 256 (1946). The Court recognized that the government had appropriated the property for its own "strictly governmental purpose" which arose from the "entrepreneurial operation" of the federal government in operating a military airfield. Penn Central, 438 U.S. at 135.

Armstrong v. United States, 364 U.S. 40 (1960), is another example of this principle. In that case, the U.S. Navy had contracted for construction of 11 boats. When the prime contractor defaulted, the Navy exercised its option under the contract to take possession of the uncompleted hulls and all the manufacturing material on hand. When the transfer to the Navy occurred, certain suppliers had not been paid and had outstanding liens against the prime contractor. The Navy, relying on sovereign immunity which made the liens invalid against the U.S., refused to pay the suppliers.

The Supreme Court concluded in Armstrong that the Navy's conduct was a taking of the suppliers' goods under the Fifth Amendment and that the Navy must pay. The Court found this was not an example of property rights being destroyed as a consequence of a valid regulatory measure. Rather, the suppliers' property rights vanished "because the Government for its own advantage destroyed the value of the liens," something which "no private purchaser could have done." Since "this acquisition was for a public use" and "the Government was the direct, positive beneficiary of the property," the Navy had to compensate. 364 U.S. at 48-49.

Finally, the Supreme Court's recent decision in Webb's Fabulous Pharmacies, Inc. v. Beckwith, 449 U.S. 155 (1980) is instructive and relevant. In Webb's, the clerk of the court of a county court in Florida appropriated the interest earned on Webb's funds which the clerk had held during court proceedings between Webb's and its creditors. There was no dispute that the original funds were private property; the question was whether the interest which had accumulated on the funds, held temporarily by the county clerk, belonged to the county. The Supreme Court had no trouble in considering this an (obviously) uncompensated taking which violated the Fifth Amendment.

It found that the appropriation of the funds was analogous to the appropriation of the use of private property for the government's benefit in Causby. 449 U.S. at 164. There was no police power justification even offered by the county. The "exaction" was a "forced contribution to general government revenues." Id., at 163. The Court concluded with the admonishment that government "by ipse dixit, may not transform private property into public property without compensation . . . ." Id., at 164. It pointed out that this was an example of the very kind of "arbitrary use of governmental power" the Fifth Amendment "stands as a shield against." Id.

2. The Government Is Acting In Its Enterprise Capacity When It Forces Insurers To Pay For Free Care In VA Hospitals.

The GAO proposal clearly runs afoul of the Constitution's protections on private property. GAO proposes legislation to prohibit provisions in group insurance contracts and in self-funded health benefit plans which exclude benefits for medical costs which are furnished to employee-subscribers by the VA free of charge. The purpose is to enable the VA to collect from private insurers and employers part of the costs it incurs in running a hospital system for veterans.

GAO's proposal is the precise kind of action which the Fifth Amendment was intended to bar. As in the Webb's case, the proposal is not a valid exercise of the police power, and it does not purport to be. GAO does not purport to be recommending the use of Congress' authority under the Interstate Commerce Clause to prevent national and widespread abuses of employee-subscribers who are beneficiaries of insurance contracts and employee benefit plans. Further, it is not claiming that it has found that the reservation to the states of regulatory power over insurers in the McCarran-Ferguson Act is no longer appropriate.[3] GAO's proposal is not even necessary to

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[3] The McCarran-Ferguson Act provides in pertinent part:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the

protect the veterans who are insured under their employers' group health policies. The insureds already are protected: a) if they choose care in a private hospital they are covered by their insurance; b) if they are provided care in a VA hospital, they do not have to pay, by statute. Thus, any attempt to justify this proposal as a valid regulation of insurers under the Interstate Commerce Clause must fail.[4]

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> Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.
>
> . . .
>
> Sec. 2.(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . . 15 U.S.C. § 1012.

[4] That Congress perceives that it cannot directly regulate insurers in this circumstance is clear from its previous actions in trying to shift Medicare and veterans' medical costs from the federal government to private insurers. On one occasion, it proceeded completely properly; in two others, it found regulatory vehicles which are arguably subterfuges for unconstitutional takings. But, in no case did Congress directly regulate insurers.

When Congress decided to limit its costs for medical care for veterans, it amended the Veterans' Benefit Act to limit the entitlement of veterans in certain circumstances to free care only when the veteran could show he did not have the means to pay for his medical care. Veterans' Benefits Act of 1958, 38 U.S.C. § 622. This action was entirely proper as it only changed the obligations of the government.

Furthermore, this effort to transfer military costs to insurers would be of questionable validity even if it were framed as a regulation of insurers under the Interstate Commerce Clause. It is difficult to postulate the regulatory justification for government intervention on behalf of the public interest to require insurers to indemnify insureds when they had not sustained a loss. Such a regulation would be seen for what it would be -- a

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In contrast, when Congress decided to shift the medical costs of the working aged from Medicare to the private sector, it chose a more circuitous, more constitutionally suspect route. (It is notable that it still did not purport to regulate insurers directly, however.) Congress amended The Age Discrimination In Employment Act to require employers to offer the same benefits to its employees over age 65 as under or face charges of age discrimination. (29 U.S.C. § 62B.) It also amended the Social Security Act to provide that Medicare would not pay benefits for the working aged to the extent they would be paid under private insurance. (42 U.S.C. § 1395y.) The Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 116, 96 Stat. 324 (1982). While this effected a transfer of funds from insurers and private employers to the government and was arguably an unconstitutional subterfuge for a taking of private property, the reliance on the Age Discrimination Act gave it at least the patina of a valid legislative action, unlike the GAO proposal.

Likewise, when Congress wanted to shift some of the costs of kidney dialysis from Medicare to private insurance, it did not regulate insurance. It amended the Social Security Act to provide that Medicare would not pay for kidney dialysis in the first 12 months to the extent that payment for such care had been made under a health insurance plan. (42 U.S.C. § 1395y.) Then it regulated the employers who sponsor group insurance by amending the Internal Revenue Code to penalize employers who discriminate in the benefits they provide to individuals with kidney disease. (26 U.S.C. § 162.) The Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2146, 95 Stat. 800 (1981).

subterfuge for a taking of private property without compensation. The courts are not unaware of attempts by governments to "deprive citizens of constitutional rights" "under the guise merely of police regulations." Mugler, 123 U.S. at 662. See discussion in footnote 5, supra.

Nor can GAO justify this action as a mere exercise of the VA's legal rights against Blue Cross and Blue Shield, similar to the VA's rights under the Federal Medical Recovery Act.[5] The Recovery Act gives the United States Government a right to sue tort feasors (and their insurers) who injure military employees. The purpose is to permit the government to recover the medical costs the government incurs in treating the injured serviceman or woman.

That rationale and legal theory, of course, is completely absent in GAO's proposal. Neither Blue Cross and Blue Shield, nor any of its subscribers, has caused an injury to any veteran which could give the VA a legal right to sue for recovery.

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[5] Congress enacted the Federal Medical Care Recovery Act in 1962. 42 U.S.C. §§ 2651-2653. The Act was enacted as a result of the holding of the Supreme Court in United States v. Standard Oil Co., 332 U.S. 301 (1947), in which the Court denied the federal government a right of action against a negligent third party for the cost of medical care provided an injured serviceman. In so holding, the Court reasoned that it was for the Congress, not the courts, to create such a liability. Id. at 314-15.

Nor can GAO proceed on any theory that the VA is a third party beneficiary of an insurance contract. The policies express a "clear indication of intent not to pay benefits when a federal law requires overlapping benefit payments." *United States* v. *Jackson*, 572 F. Supp. 181, 185 (W.D. Mich. 1983).[6]

Instead, the proposal is a stark example of the arbitrary use of government power to acquire resources necessary for the government tc operate. This proposal is, in effect, to cause a direct transfer from health insurers and employers to the VA of millions of dollars to provide the government with resources to meet the obligations the government has undertaken to care for veterans. As in *Armstrong*, the government is acting for "its own advantage" and it will be the "direct, positive beneficiary" of the funds it wants to appropriate from insurers. *Armstrong*, 364 U.S. at 48-49.

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[6] Similarly, the Government cannot recover its costs under the Recovery Act from the tort victim's insurance company. Jackson, 572 F. Supp. at 184-85. Rather, such right of recovery is independent of the Act and turns on whether the United States is an insured within the meaning of the policy at issue (*e.g.*, Government Employees Insurance Co. v. United States, 376 F.2d 836, 837 (4th Cir. 1967) (allowing recovery); United States v. Allstate Insurance Co., 306 F. Supp. 1214, 1214-15 (N.D. Fla. 1969) (denying recovery)), or is deemed a third-party beneficiary under the policy (*e.g.*, United States v. United Services Automobile Ass., 431 F.2d 735, 737 (5th Cir. 1970), *cert. denied*, 400 U.S. 992 (1971)).

This attempt to exact a "forced contribution to general government revenues" (449 U.S. at 163) is indistinguishable from the governmental actions in Webb's and Armstrong which the Supreme Court found to be unconstitutional. The federal government, acting in its enterprise capacity to care for veterans, simply wants to offset its own obligations with private funds.

CONCLUSION

The GAO proposal is unconstitutional. If enacted, such a law would violate the guarantees of the Fifth Amendment of the Constitution against governmental appropriations of private property without just compensation. The purpose of the statute is to confiscate corporate funds for governmental use rather than to regulate health insurance products offered in interstate commerce.

The proposal represents the exact kind of overreaching by an over-zealous government which the Constitutional protection was designed to prevent. The fact that the Fifth Amendment was probably adopted in response to the Revolutionary War abuses by the government in obtaining supplies for the army "by impressment, as was too frequently practiced" only serves to reinforce this conclusion. Sax, supra at 58 (quoting Tucker's Blackstone, Commentaries 305-06 (appendix) (1803)). And though the circumstances change, the dangers of arbitrary government do not. Justice Rehnquist recently warned against the dangers inherent in situations such as this where governments have financial problems. *Penn Central*, 438 U.S. at 153 (Rehnquist, J., dissenting). The danger is, he said, that in searching for solutions, "some may believe that certain costs will be more easily borne by corporations" than the taxpayers. But the financial problems should not allow us to achieve "a shorter cut than the constitutional way."

MILLER & CHEVALIER, CHARTERED

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April 25, 1985

The Honorable Frank H. Murkowski
U.S. Senate
317 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Murkowski:

As you requested, enclosed are our comments on the recent General Accounting Office report "Legislation to Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings" (GAO/HRD-85-24). Staff of the Blue Cross and Blue Shield Association were interviewed by the GAO during its investigations. We were not, however, provided an opportunity to review and comment on the report prior to its issuance.

We believe that the GAO analysis is seriously flawed. In particular, the following problems exist:

1. In assuming that there would be minimal impact on health insurance premiums, GAO omitted any analysis of the unevenness of the cost impact of the proposal on employers and employees.
2. GAO's analysis did not take into account the concern that employers and insurers would not be able to apply the wide variety of cost containment mechanisms they now use by employers and insurers, and its conclusions about private sector utilization review (UR) programs result from a misunderstanding of UR as it is practiced by many private organizations today.
3. GAO's legal analysis does not fully address the fundamental constitutional issue. In the opinion of our outside counsel, Miller & Chevalier, Chartered, the proposal is unconstitutional.
4. GAO underestimated the administrative costs involved.

We believe these problems raise serious questions about the validity of the GAO's conclusions and recommendations. Our detailed comments on these points, plus our specific concerns about the adequacy of the GAO's study methodology, are enclosed.

Also enclosed is the detailed legal analysis conducted by Miller and Chevalier. If you have any questions, please contact me at 783-6222.

Sincerely yours,

Mary Nell Lehnhard
Vice President

cc: The Honorable Charles A. Bowsher
Comptroller General

Enclosures

Detailed Comments of the Blue Cross and Blue Shield Association on General Accounting Office Report, "Legislation to Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings" (GAO/HRD-85-24).

April, 1985

BACKGROUND

By law, the United States provides free medical care in VA hospitals to certain veterans. Some veterans are also covered by private health benefit plans provided through their employers or the employers of their spouses.

Because the fundamental purpose of insurance is to protect individuals against financial loss, there are no benefits payable under private insurance when veterans receive care free of charge at VA facilities. Insurance contracts typically have "exclusionary clauses" which restate this rule of nonpayment for free care, however, the concept is fundamental to the principle of insurance and not dependent on such clauses. Insurance contracts may also specifically exclude payment for care provided by government hospitals and that also has grown out of the fact that government hospitals generally do not charge for care provided to patients meeting eligibility criteria.

The effect of this principle of nonpayment for free care is reflected in the cost of insured and self-funded employee health benefit plans. Because the costs reflect only expenses actually incurred by the group, the costs are lower to the extent that employees use VA facilities or any other facilities that do not charge for their services.

The GAO is proposing that Congress require insurers and self-funded plans to pay for care the VA provides free of charge. The legislation would attempt to accomplish this by voiding the contract exclusions in group insurance contracts and self-funded plans that exclude benefits for free care insofar as they apply to veterans' hospitals. The purpose of this legislation is to transfer, according to the GAO's estimates, about $100 million or more from private insurance to the government to reduce the government's expenditures for care of veterans in VA hospitals.

A number of parties have raised serious problems with such legislation. The General Accounting Office (GAO) examined these in a report entitled "Legislation to Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings" (GAO/HRD-85-24).

The following are the comments of the Blue Cross and Blue Shield Association on the GAO analysis:

I. Cost Impact on Private Sector Employers, Employees, and Insurers

In assuming that there would be minimal effect on private health insurance premiums, the GAO minimized the importance of the fact that premium cost increases resulting from mandated third-party payments to the VA would be concentrated on particular employers and employee groups. For these groups, the added costs may be several times as large as the national average.

Specific data are limited, but two types of concentration should be expected: geographic concentration and concentration on certain types of groups.

Geographically, the burden of costs will fall disproportionately on areas in which there are (is):

1) large proportions of veterans in the population;

2) an above average percentage of veterans who are older—and, therefore, use more care; and

3) more use of VA care than the national average, given the number and age distribution of veterans. (This typically occurs where the number of VA hospital beds exceeds the national average.)

Quantitative information is available on this third point. It shows twenty-three metropolitan areas in which the number of veterans discharged from VA hospitals is more than twice what would be expected based on national averages even after taking account of the number of veterans in the area and their age distribution. These high use areas are:

Metropolitan Area	Ratio of Actual to Expected Discharges
Alexandria, LA	3.5
Amarillo, TX	2.2
Asheville, NC	3.0
Augusta, GA	2.9
Biloxi-Gulfport, MS	2.5
Boston, MA	2.6
Fayetteville, NC	2.2
Fayetteville, AR	3.0
Gainesville, FL	2.4
Jackson, MS	2.8
Killeen-Temple, TX	3.4
Lexington, KY	2.3
Lincoln, NE	2.4
Little Rock, AR	2.6
Montgomery, AL	2.5
Pine Bluff, AR	2.0
Reno, NV	2.1
Roanoke, VA	2.5
Shreveport, LA	2.2
Sioux Falls, SD	2.4
Topeka, KA	3.2
Tuscaloosa, AL	2.1
Waco, TX	3.7

Source: Calculated based on VA data and methodologies used in the 1984 VA report, Caring for the Older Veteran. See "Metropolitan Statistical Area Based Method" p. I-3 in Appendix I.

With regard to the effect on particular types of groups, a concentration of new costs would be expected among employers with high proportions of veterans (e.g. those with high proportion of middle-aged male employees). The proposal would also have a disproportionate effect on low-wage employers with relatively limited insurance. In order to receive free care in a VA facility, most insured veterans have to testify to their inability to pay for care; inability to pay is more likely among veterans with low wages and limited insurance (i.e. insurance that requires high out-of-pocket expenditures.) The response of employers affected by the proposal in a disproportionate manner is uncertain; it is reasonable to expect, however, that a reduction in covered benefits or cancellation of coverage entirely would occur in some cases.

II. Private Sector Cost Containment Efforts

The GAO's report fails to recognize that the proposal would transfer major new costs to selected employers who would be unable to apply the same cost containment programs to their employees using VA facilities as they apply to other employees. The GAO report claims incorrectly that mandated payment to the VA would not create serious problems for private utilization management. Their conclusion is based, in part, on a misunderstanding of the foundation and scope of private health benefit cost management strategies. In particular, the GAO minimized the importance of both subscriber and provider incentives to cooperate with these strategies. Also, the GAO report does not address the lack of independent financial audit of VA costs or the inadequacies of the VA's own utilization review efforts.

A. Subscriber Incentives

A wide range of activities are necessary to support the implementation of effective utilization management strategies. Appropriate financial incentives for subscribers, as well as education, are critical to these activities. One incentive for the subscriber is the risk of bearing a greater out-of-pocket cost if he or she does not cooperate with the payer's utilization management program. This greater cost-sharing can come through the reduction or denial of benefits to the subscriber. Selectively applied, patient cost-sharing incentives support what are probably the most effective cost containment programs currently in the marketplace: mandatory ambulatory surgery, second surgical opinions for elective surgery, pre-admission review of the medical necessity of hospital stays, and preferred provider arrangements.

The legislative proposal recommended by the GAO does not allow for patient cost-sharing for insured veterans who use VA health facilities. As a result, these veterans would be exempt from the incentives that are critical to the success of the specific cost containment programs previously mentioned. In addition, to the extent that the overall patient cost-sharing features of the private health benefits plan deter the excessive use of services, this advantage would be lost for the veteran with private coverage. For some employers with high proportions of veterans in areas with VA facilities, the exemption of certain employees from cost-containment provisions could be a real cost and employee morale problem.

In summary, the legislation recommended by the GAO would negate an important and effective mechanism to manage utilization — and then would require insurers and employers to pay for the excessive use of care that would take place in its absence.

B. Provider Incentives

In addition to subscriber incentives, private sector cost containment programs also depend heavily on cooperation from providers. While the GAO report acknowledges that the "VA remains opposed to having insurance companies review the effectiveness of VA utilization review programs" (p. 51), it minimizes the problems that this fundamental lack of cooperation would cause for a wide range of other private sector cost containment programs. These include:

- Mandatory ambulatory surgery — It is not clear that the VA would honor an employer's mandate that certain procedures be performed on an outpatient basis. Indeed, the VA has placed little emphasis on ambulatory surgery.
- Mandatory second surgical opinion — The VA is apparently not willing to accept a requirement that private sector physicians review its physicians' medical decisions.
- Pre-admission certification — Again, the GAO report suggests that the VA is not ready to accept outside direction or oversight of its operations by the private sector.
- Concurrent review.
- Discharge planning.
- Medical practices audits.

The Minnesota Blue Cross and Blue Shield's AWARE program is one example of the effective use by the private sector of both provider and subscriber cost containment incentives. It depends on contracts with hospitals under which they accept length of stay screens and participate in special utilization review programs. The AWARE hospital contract is backed up by physician contracts that require set terms for specialty and hospital referrals, utilization review, and other cost-containing practices. In addition, subscribers have financial incentives to use AWARE providers and to otherwise cooperate with cost containment programs. Other Plans have similar programs that include both subscriber and provider incentives to avoid hospitalization and lengthy hospital stays.

The legislative proposal recommended by the GAO would tend to undermine the cost-containing incentives of programs like AWARE not only as they affect subscribers but also as they affect providers. Providers operating in a competitive environment have reasons to demonstrate efficiency to private payers that VA hospitals will not have. In fact, as unilateral and uninhibited price setters, the VA would have every reason to inflate prices, yet the proposed legislation provides inadequate protections for the private sector to counter this.

C. Financial Audits

Under the legislative proposal, insurers would not be able to audit VA financial records. GAO notes that current reimbursement legislation authorizes recovery of the "reasonable value" of care provided and cites court rulings that the OMB-established charges for VA care cannot be challenged as unreasonable by a liable third party.

While we doubt the validity of those cases which hold that the agency's decision cannot be reviewed even under the "arbitrary and capricious" standard of the Administrative Procedure Act, it is apparent that the Veterans' Administration would have considerable latitude in establishing a reimbursement rate which it deems to be reasonable. There is evidence to indicate that the VA would be generous to the government in establishing that reimbursement rate. For example, we understand that in 1985, the rate charged the private sector in tort cases is 22% higher than the rate the VA charges other government agencies. Part of this difference apparently is due to changes in VA's costing practices. Private payers would find it very difficult to prevent these practices. The legislation GAO endorses, therefore, would not provide payers with the financial safeguards that GAO routinely recognizes as appropriate and necessary when it reviews the operations of government programs.

D. VA's Utilization Review Efforts

Another serious problem is that the GAO report overlooks the fact that utilization review (UR) in VA hospitals is weak compared to that found in non-Federal hospitals, the setting in which private insurers do pay bills. Only half of VA hospitals have UR coordinators, and only about half of those coordinators are full-time. As the GAO report notes, VA length of stay for acute medical and surgical patients is about 70% greater than the length of stay for comparable patients in community hospitals. We understand that little of the VA's UR is directed at reducing and eliminating avoidable days of care. The VA's attitude toward extra days of care is illustrated by the following statement included in an official VA document: "An additional few days of hospitalization may be considered preferable to having patients who reside some distance from a VA medical center return soon after for follow-up outpatient care." (Veterans Administration, Fiscal Year 1986 Budget Estimates Vol. II: Medical Appropriations and Funds, pp. 5-5 and 5-6.)

In contrast, in non-Federal hospitals, UR is nearly universal and very much focused on avoidable days of care. In short, VA hospitals appear to lack the utilization control mechanisms which are an important part of the environment in which insurance reimbursement normally operates.

III. Legal Problems

We believe that, in finding that there are no overriding legal problems with implementation of a cost recovery program, the GAO dealt only with peripheral issues and skirted a central constitutional issue. The purpose of insurance is to protect - indemnify - a subscriber against a financial loss. Thus under the terms of insurance contracts, there are no benefits payable for care for which the insured has no obligation to pay.

Because of the absence of any financial liability on the part of veterans using a VA facility, we believe that the GAO proposal, which is based on S. 759, would violate the guarantees of the Fifth Amendment of the Constitution against governmental appropriation of private property without just compensation. The purpose of the proposal is to confiscate corporate funds for governmental use rather than to regulate health insurance products offered in interstate commerce.

Our analysis follows:

The Fifth Amendment of the Constitution of the United States requires that no "private property be taken for public use, without just compensation." The purpose of the Amendment is to "bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." Armstrong v. United States, 364 U.S. 40, 49 (1960). The clause was designed to prevent the "arbitrary use of governmental power" to exact "forced contributions" to the government. Webb's Fabulous Pharmacies Inc. v. Beckwith, 449 U.S. 155, 164 (1980).

A. The Government Cannot Take Property Without Compensation In the Conduct of Its Own Enterprises.

The Supreme Court has recognized that the principles of justice and fairness in the Fifth Amendment require that government must pay for intrusions on property rights when the government is appropriating property for its own use to enable it to operate one of its governmental functions, or one of its "enterprises." [1] The government acts in an enterprise capacity when it does such things as operate a post office, build roads and dams or maintain an army. Sax, Takings and the Police Power, 74 Yale L.J. 36, 62 (1964); Penn Central Transp. Co. v. New York City, 438 U.S. 104, 135 (1978).

As the Supreme Court has recently pointed out, a classic example of this is the case of United States v. Causby. Penn Central, 438 U.S. at 135. In Causby, low-flying airplanes landing at a military airport destroyed the utility of a neighboring farm, and the government was required to pay for the property. United States v. Causby, 328 U.S. 256 (1946). The Court recognized that the government had appropriated the property for "entrepreneurial operation" of a military airfield. Penn Central, 438 U.S. at 135. See also Armstrong v. United States, 364 U.S. 40, 48-49 (1960) (Navy must pay materialmen's liens on supplies for boats since it was the "direct, positive beneficiary of the property" acquired); Webb's Fabulous Pharmacies, Inc. v. Beckwith, 449 U.S. 155, 164 (1980) (appropriation by clerk of county court of interest on funds held by the court unconstitutional as "forced contribution to general government revenues").

B. The Government is Acting in Its Enterprise Capacity When It Forces Insurers to Pay for Free Care in VA Hospitals.

GAO's proposal is the precise kind of action which the Fifth Amendment was intended to bar.

The proposal is not a valid exercise of the police power, and it does not purport to be. GAO does not purport to be recommending the use of Congress' authority under the Interstate Commerce Clause to protect beneficiaries of insurance contracts. It is not claiming that state regulation of insurers under the McCarran-Ferguson Act (15 U.S.C. 1012) is no longer appropriate. GAO's proposal is not even necessary to protect the veterans who are insured under their employers' group health policies as their status will not change (except to the extent they might pay higher insurance premiums); the veterans do not pay for the care under existing law, and they will not pay for the care under the proposed legislation. Thus, any attempt to justify this proposal as a valid regulation of insurers under the Interstate Commerce Clause must fail.[2]

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[1] This principle is to be distinguished from the general right of the government to intrude on private property, and affect the property's value adversely, without compensation, in the lawful exercise of its police power. For example, the government can close down a plant, because its operation is hazardous to the public health, without compensating the owner. Mugler v. Kansas, 123 U.S. 623 (1887). But, the courts have sometimes found that regulation even under the police power goes too far, and the interests of fairness require compensation. Goldblatt v. Hempstead, 369 U.S. 590, 594 (citing Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 415 (1922)).

Nor can GAO justify this action as a mere exercise of the VA's legal rights against insurers similar to VA's rights under the Federal Medical Recovery Act. 42 U.S.C. 2651-2653. That Act gives the government a right to sue tort feasors (and their insurers) who injure military employees to recover the medical costs the government incurs. The statute has no effect on the contractual rights of insurers and their insureds.

This proposal is entirely different. First, neither the insurers nor any of their subscribers have caused an injury to any veteran which could give the VA a legal right to sue for recovery. Second, unlike the Recovery Act, this proposal would vitiate basic provisions of contracts between an insurer and its insureds.

The proposal is a stark example of the arbitrary use of government power to cause a direct transfer of millions of dollars from health insurers and employers to the VA to provide the government with resources to meet the obligations the government has undertaken to care for certain veterans. As such, this attempt to exact a "forced contribution to general government revenues" (*Webb's*, 449 U.S. at 163) is indistinguishable from other similar actions by the government in its enterprise capacity which the Supreme Court has found to be unconstitutional.

The fact that the Fifth Amendment was probably adopted in response to the Revolutionary War abuses by the government in obtaining supplies for the army "by impressment," only serves to reinforce this conclusion. Sax, *supra* at 58. And though the circumstances change, the dangers of arbitrary government do not. Justice Rehnquist recently warned against easy solutions sought by governments with financial problems. *Penn Central*, 438 U.S. at 153 (Rehnquist, J., dissenting). The danger is "some may believe that certain costs will be more easily borne by corporations" than the taxpayers. But the financial problems should not allow us to achieve " a shorter cut than the constitutional way."

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[2] That Congress perceives that it cannot directly regulate insurers in this circumstance is clear from its previous actions in shifting Medicare and veterans' medical costs from the federal government to private insurers. Once, when it limited the entitlement of veterans in certain circumstances to free care *only* when the veteran could show he did not have the means to pay for medical care, it proceeded completely properly. Twice — when it decided to shift the medical costs of the working aged and individuals with kidney disease from Medicare to the private sector — it found regulatory vehicles which are arguably subterfuges for unconstitutional takings. But, in no case did Congress directly regulate insurers.

IV. VA Administrative Costs

We believe that GAO understated greatly the administrative costs that the VA would incur to implement the proposal.

First, GAO's estimate for administrative costs are based on billing for inpatient care only. However, the VA system provides approximately 20 times as many outpatient visits as inpatient episodes of care. If insurance coverage for outpatient care is about as widespread as coverage for inpatient care, then GAO estimates of VA administrative costs should be multiplied about twentyfold. (Because much VA outpatient care is pre- or post-hospitalization care, insurance coverage of it will, in fact, be relatively extensive.) As stated in appendix VIII to the GAO report, the VA estimates its administrative costs at approximately $50 million a year; GAO's estimate is approximately $1.7 million. Most of this difference is due to the number of bills involved. We believe the VA's estimate is the more realistic.

Second, GAO assumes the VA is already carrying out one of the three tasks involved in billing—namely, ascertaining which veterans have insurance coverage. (See pp.23-25 of the GAO report.) In reality, this function may be stipulated in the VA procedure manuals, but almost certainly receives minimal attention since it now rarely serves any purpose. This view is confirmed by the GAO report figure that 6% of a group of patients were identified as insured by the VA administrative process. This figure is only a fraction of what other surveys have estimated, and probably is evidence that the coverage determination stipulated in the manuals is not taken seriously. Thus, contrary to GAO, the VA would incur additional administrative costs simply to find out if veterans have insurance.

Third, GAO assumes that each inpatient episode of care will involve a single bill. In reality, coverage for physicians' services often involves a different insurer than does coverage for hospital care, and it is not uncommon for the major medical protection to be underwritten by a third carrier. These additional billings would increase administrative costs.

The understatement of VA administrative costs is also suggested by the experience of the Massachusetts state veterans nursing homes which GAO examines in its report. These homes cite administrative costs for billings of 12-13% of collections.

V. Methodological Problems

There are two potentially serious flaws in the methodology used by the GAO to estimate expected VA recoveries.

First, of an original sample of 2,693 veterans, GAO received usable replies from only 1,356—or 50%. Approximately 70-80% is the lowest response rate generally considered necessary to assure unbiased responses. Below that level, it is considered too likely that respondents differ from non-respondents and that the survey results are, therefore, not reliable. There is some evidence of this problem in GAO's figures that 6% of non-respondents were reported by the VA's administrative process to have insurance, while 18% of respondents were found by the GAO survey to have insurance.

Second, the GAO estimates are based on what veterans' insurance covered at the time of the 1982 survey and on general provisions of health insurance at about that date--or even a year or two earlier. (See pp. 17-18 of the report.) This early 1980's base misses the enormous surge in deductibles and coinsurance for inpatient care that has occurred since then. For example, a Hewitt Associates' survey showed the following very large differences between employee benefit plans in 1982 and in 1984:

Plans with	1982	1984
Deductible for inpatient hospital care	30%	63%
Coinsurance for inpatient hospital care	33%	58%
Deductible for inpatient surgery	34%	59%
Coinsurance for inpatient surgery	58%	74%

In short, insurance will pay for less than it would have at the time GAO did its field work. The very rapid growth of HMOs and of other insurance arrangements which only pay for care if it is obtained from selected providers reinforces this conclusion.

SUMMARY AND CONCLUSION

Based on the foregoing analysis, we believe that the GAO report is seriously flawed. In particular, the following problems exist:

1. In assuming that there would be minimal impact on health insurance premiums, GAO omitted any analysis of the unevenness of the cost impact of the proposal on employees.

2. GAO's analysis did not take into account the concern that employers and insurers would not be able to apply the wide variety of cost containment mechanisms now used, and its conclusions about private sector utilization review (UR) programs result from a misunderstanding of UR as it is practiced by many private organizations today.

3. GAO's legal analysis does not fully address the fundamental constitutional issue. In the opinion of our outside counsel, Miller & Chevalier, Chartered, the proposal is unconstitutional.

4. GAO underestimated the administrative costs involved.

We believe these problems raise serious questions about the validity of the GAO's conclusions and recommendations.

Chairman MURKOWSKI. Does Mr. Briggs have any comments?

Mr. BRIGGS. Yes, sir; I certainly do.

Chairman MURKOWSKI. Good.

Mr. BRIGGS. I am here to speak for the Health Insurance Association of America. And we represent the insurance companies that insure about 85 percent of the insured public, other than the Blue Cross folks. And we are very pleased to have this opportunity to talk about this problem.

If I can respond to your question having to do with the windfall, I would just like to agree with my colleague here that the insurance companies in fact charge a premium that is necessary to collect—cover the claims and the expenses which are incurred. And we are in a very competitive business and we try to charge as low a price as we can to get the business.

And most cases reflect their own experience in terms of claims and expenses. And as a result, if there is any savings which result from patients going to VA hospitals those are reflected in the rates and there is not any windfall that exists.

Chairman MURKOWSKI. I am sorry, I did not hear the last statement.

Mr. BRIGGS. I said there is no windfall that exists.

Chairman MURKOWSKI. Well, let's call it something else. There is something that exists that benefits those participants in the plan as a consequence of the fact that there is funding coming in without any exposure to a specific number of that particular group, namely, those——

Mr. BRIGGS. You are correct, sir.

Chairman MURKOWSKI [continuing]. Veterans that have that coverage as part of their employee benefits, which constitute, I am told, 17 or 18 percent of the veterans' population.

Mr. BRIGGS. To the extent, to the extent that employees do use veterans' facilities then there is a saving and that saving is reflected in the experience. And the experience is what is the basis for the rates.

Chairman MURKOWSKI. The way the program works now, it is not a windfall but it is beneficial that——

Mr. BRIGGS. Yes, sir.

Chairman MURKOWSKI [continuing]. This comes in——

Mr. BRIGGS. Yes, sir.

Chairman MURKOWSKI [continuing]. As a contribution from the employee——

Mr. BRIGGS. Yes, or another way——

Chairman MURKOWSKI [continuing]. And the employer, and benefits primarily those remaining in the system that use the insurance coverage?

Mr. BRIGGS. Indeed. Indeed. Or to put it another way, sir, if there was no VA system the costs would be higher for everyone.

Chairman MURKOWSKI. So you would not suggest that the VA in effect indirectly subsidizes the system?

Mr. BRIGGS. I am saying, sir, that the Congress in its wisdom saw fit to pass a bill——

Chairman MURKOWSKI. Careful now.

Mr. BRIGGS [continuing]. To pass a bill which would provide, which would provide veterans with benefits free of charge.

Chairman MURKOWSKI. Yes, but this kind of a benefit is a benefit to the private sector.

Mr. BRIGGS. It may turn out to be somewhat a benefit, yes, indeed. Indeed.

Chairman MURKOWSKI. Well, you just acknowledged that it was. What do you call this? It is not a subsidy, it is not a windfall; what is it?

Mr. BRIGGS. It is a savings.

Chairman MURKOWSKI. A savings. To?

Mr. BRIGGS. To the employers, presumably, whoever is paying the bill, which is primarily the employers.

Chairman MURKOWSKI. Well, employer, employee.

Mr. BRIGGS. Yes.

Chairman MURKOWSKI. But it is to the private sector's——

Mr. BRIGGS. Yes, sir.

Chairman MURKOWSKI [continuing]. Benefit.

Mr. BRIGGS. Surely.

Chairman MURKOWSKI. At the expense, theoretically——

Mr. BRIGGS. Of the taxpayer.

Chairman MURKOWSKI. Of the taxpayer. That is what I wanted to hear.

Mr. BRIGGS. Yes, sir.

Ms. LEHNHARD. Mr. Chairman, I would note that the VA, they have mentioned they did not have a position on this this morning. And in the conference report on Public Law 96-330, it is noted that the VA acquiesced that there is no subsidy involved, no windfall profit, no reaping of a windfall.

Chairman MURKOWSKI. At the expense of the taxpayer.

Ms. LEHNHARD. They acknowledge that, yes. And the more veterans an employer hires the more he saves.

Chairman MURKOWSKI. I am told that and the paper says that GAO states on pages 30 and 31 of their report that they have tried to obtain information on your administrative costs. But they report that the health insurance association does not compile data due to regional differences between Blue Cross and Blue Shield. It says that Blue Cross and Blue Shield would not give it to them. Why?

Ms. LEHNHARD. Mr. Chairman, I would respond that my office, the Office of Government Relations, which is I think is a logical contact, was never contacted by the GAO. We in fact knew about this report after it was finalized and ready to issue.

Now, some of our Blue Cross and Blue Shield plans were contacted individually, but the association office that represents them was not. And I am sure we would have been pleased to provide administrative information and data.

Chairman MURKOWSKI. In other words, you would give it to them if they asked you?

Ms. LEHNHARD. We would be glad to sit down with them and go over what we could. Probably to the limits of what we were concerned about being printed is proprietary information in a public document. But I am sure there is lots we could give them within that parameter.

Chairman MURKOWSKI. OK. Well, that ought to clear that one up.

Mr. Briggs.

Mr. **Briggs**. Yes?

Chairman **Murkowski**. On page 8 of your written testimony you state that "the administrative costs to the VA, in adjusting its procedures to comply with requests for payment information, might significantly offset any potential recoveries received by the Government."

Could you comment on that?

Mr. **Briggs**. Well, I think the problem was that it was our understanding that the VA did not have their records in such form as to provide us with the information that would be normally needed. The kind of information which most community hospitals have we understood the VA did not have. Now, if that is incorrect information, sir, then we stand corrected. But that was our understanding.

Chairman **Murkowski**. Would anybody from the VA care to nod their head whether we have it or do not have it? I do not know. Ma'am? Ms. Quandt?

Ms. **Quandt**. Mr. Chairman, we have them and can provide them. They are the UB–82's, standard form industrywide for third-party payers.

Chairman **Murkowski**. Would that satisfy you?

Mr. **Briggs**. Yes; it would.

Chairman **Murkowski**. Good. Well, we got that taken care of. GAO.

Ms. **Lehnhard**. Mr. Chairman.

Chairman **Murkowski**. Go ahead, make any statement you want. I am through.

Ms. **Lehnhard**. I think we were both responding to your questions. And I will keep my remarks very short. But I would like to respond to a second set of concerns that we have. And that reflects the current efforts to control health care costs in the community, efforts by employers right now.

As you know, there is a lot going on in the marketplace just in the last 24 months; activities have changed dramatically. All of these cost containment programs focus on avoiding unnecessary hospital care. And I would note that the draft report by the GAO which is, I understand, to be issued shortly, notes that about 30 to 40 percent of all hospital stays in the VA facilities are avoidable.

In fact, when a PRO organization, an outside PRO organization looked at the VA's utilization initiative program they found that they missed 9 out of 10 unnecessary stays.

Chairman **Murkowski**. The VA misses 9 out of 10?

Ms. **Lehnhard**. Their own utilization program. Now, these programs do not exist in every hospital, according to the GAO report.

The programs that we are using that are successful are programs that you are aware of: Preadmission review, outpatient surgery, second opinion for surgery. And I would emphasize that all of these programs are dependent, entirely dependent on the employee being at financial risk. Usually if he does not comply with the rules involved in these programs he gets a higher co-pay and deductible.

Under the VA proposal the employee is not at risk; if he does not want to comply he goes to a VA hospital; he does not have to incur those higher deductibles and co-pays and the employer has to pay.

Employers are also, and insurance companies, are relying on deductibles and co-pays just to deter unnecessary utilization.

I sit on the health committee of the chamber of commerce. And this elicited the strongest reaction from major employers, that they would not be able to apply deductibles and co-pays to their employees. They were further concerned that they are going to have two classes of employees: One that has to meet all these rules about cost containment—which they do not like, including the deductibles and co-pay—and another class that does not have to meet those rules. And the employees are not going to know whether it is the Government rules, the employer rules, and they are going to have some major employee problems at a time where they are trying to get them to accept the new cost containment activities.

The last point I would mention is that one of the most successful things we are doing to control costs—and it was mentioned this morning—and it is contracting with selected hospitals in the community. Now, these community hospitals agree to accept a lower price, or more often they accept, they are willing to undergo more stringent utilization control.

Chairman **Murkowski**. What about care? Lower price for lower care?

Ms. **Lehnhard**. Most of it is based on their willingness to accept strong utilization control. This is the HMO type arrangement and selective contracting; we call them PPO's—preferred provider arrangements.

It was stated very clearly this morning that the VA is not willing to play by those same rules that other hospitals have to play by.

Chairman **Murkowski**. I did not hear that.

Ms. **Lehnhard**. They said, for example, if a hospital were not willing, if the VA could not contract and meet the terms of an employer's contract either in an HMO setting or a PPO setting, they would collect anyway. And this is precisely what we are concerned about. Even though there is language in the bill that sends mixed signals, but I think it is intended to show that they would comply with some of the rules in the private sector.

I think that the attitude this morning reflects what in actuality happens, that they would try, and when it did not work they would take the money anyway.

We think the only way that most containment works is if the employee and if the facility is at risk. And under the VA proposal neither one is at risk. And we just do not think the cost containment strategy that we are finding successful now and employers are finding successful can work.

And I conclude by saying on the basis of that we would ask you to deny the request for this new authority.

Chairman **Murkowski**. Well, I have a hard time responding to that with a yes or no answer now. And you probably would not want me to.

I have heard the contention made by the VA numerous times that their actual cost is less than the private sector.

Ms. **Lehnhard**. You know, these days we do not worry——

Chairman **Murkowski**. As a consequence have you thought of the possibility that you could lower your actuarial figures by reimbursing for care through the VA system instead of increasing it?

Ms. **Lehnhard**. I would say that the marketplace has finally realized that price does not count as much as quantity. We are finding that if we can work with hospitals to get them to avoid admitting patients, get those patients out earlier, get rid of that unnecessary utilization, the price is less significant.

Our cost equals price times quantity. And we are having much more success in controlling that quantity.

And if the GAO study shows anything it is that the VA has a very high quantity ratio.

Chairman MURKOWSKI. Well, maybe it is the issues such as this that will require the VA to try and do a better job in that area and still give the same quality of care.

Can you give us any estimates, in your opinion, as to what this savings at the taxpayers' expense amounts to in dollars, based on 17 or 18 percent of the veterans' population that has this dual insurance?

Ms. LEHNHARD. No, we could not. And I would put that savings in the same context as the fact that employers do not pay for anything that is free. For example, many times employees go to a community hospital and they get free drugs because they are experimental. Employers do not pay for that. That is a savings to them.

In fact, if this bill does anything it sets a precedent for employers having to pay for all the free care, including community screening services and everything else.

Chairman MURKOWSKI. Well, now just a minute. The employer is already paying for.

Ms. LEHNHARD. No. An employer is not paying when his employee goes to the VA facility.

Chairman MURKOWSKI. No, not now. But under the proposed legislation. Currently the employer and the employee are making this contribution. You indicate that you cannot give us any idea how much that amounts to from the standpoint of what constitutes a savings to the private sector health carriers. I find that basically unacceptable that you cannot give us some estimate. You know you can apply a percentage and a factor and come up with a wide-range estimate. I am sure I could give it to the GAO and they would throw a figure at it. You would probably counter the figure. But to just suggest that no, you cannot do it, I do not find that basically acceptable.

Ms. LEHNHARD. I understand the logic of your questioning. But we do not even know when these people use VA facilities. There is no reason for us to, they do not even enter our claim system.

Chairman MURKOWSKI. Well, take 17 percent and assume you do not have any cost associated with that 17 percent and see what it equates to.

Ms. LEHNHARD. But we will have some cost because they may want to use community hospitals for some things and not others.

I am sorry I cannot respond. But I think you could maybe make ballpark estimates. But I do not even know how you would arrive at those; I am not a statistician.

Chairman MURKOWSKI. Well, a lot of people are not statisticians. I am not going to pursue the questioning, but I think to suggest that it is not in the interest of this committee to concern itself with the realities associated with substantial savings which have been indicated by previous testimony, you heard the figures and so did I of what it means—some $65 million in fiscal year 1986 and $258 million in fiscal year 1990—that we could just dispense with it by a request from the private sector.

I am not speaking for my colleagues, but obviously, this is an area where the Federal Government sees an opportunity to not necessarily reduce its overhead, but rather to basically change procedure. From the standpoint of health care provided to the veteran, the quality certainly should not be reduced, it should be basically the same.

The question, I guess, is whether the veteran is going to want to use the VA facility. I assume he will, but I do not know that.

Mr. **Briggs**. Mr. Chairman, could I——

Chairman **Murkowski**. Yes, go ahead.

Mr. **Briggs**. Can I make a point here?

Chairman **Murkowski**. Sure.

Mr. **Briggs**. It seems to me that there is a very basic issue here. Does the veteran have a financial obligation to pay for the care? If that financial obligation exists then the insurance is, as I understand it, perfectly willing to reimburse that veteran for the care that he has been billed for.

Should I repeat that statement?

Chairman **Murkowski**. Yes.

Mr. **Briggs**. It is a very important one.

I say the insurance industry is prepared to reimburse a veteran who is indeed billed for the cost of care, whether it be in a veterans' hospital or any other place. Our basic problem is reimbursing someone for a cost that they do not have, that did not incur.

If the system were to provide that the veteran is indeed obliged to pay for that care, then if he is covered by insurance we would pay for it. And we have no problem doing that. The basic principle here is that we do not see why we should reimburse someone for costs they have not incurred.

Chairman **Murkowski**. Well, that is fine. But then why should you collect?

Mr. **Briggs**. We do not collect, sir. We have been through this several times.

Chairman **Murkowski**. Well, in fact there is a contribution. And you indicated it was a savings at the taxpayers' expense.

Mr. **Briggs**. Sir, the premium rates charged reflect the degree of saving that may exist.

Chairman **Murkowski**. That is true. But it is at the expense, the savings to and expense of the Government. Savings to the private employer——

Mr. **Briggs**. Yes, sir.

Chairman **Murkowski** [continuing]. Expense to the Government.

Mr. **Briggs**. Yes, sir.

Chairman **Murkowski**. Is that a legitimate underwriting obligation of the Government? That is the question asked.

Mr. **Briggs**. Well, I think the Government passed a law that made it happen, sir.

Chairman **Murkowski**. Well, I know. But see, now the Government is looking at some other laws. And basically the whole card is how can we continue to maintain the quality of care without substantially finding other sources of revenue?

Ms. **Lehnhard**. Mr. Chairman.

Mr. BRIGGS. Well——

Chairman MURKOWSKI. This is a potential revenue source. The testimony has already been given with regard to the fact that the collection is made, the deduction is taken, and there is a benefit for those participants in the program, in that there are private sector participants. That technically, is the question.

Mr. BRIGGS. But would you agree, sir, would you agree, sir, that it is not fair to ask the private sector to pay the cost of a benefit which has been passed by Congress?

Chairman MURKOWSKI. Well, when you say a benefit that has been passed by Congress——

Mr. BRIGGS. Well, Congress has decided to provide these benefits free of charge to veterans.

Chairman MURKOWSKI. That is right. But Congress——

Mr. BRIGGS. Now, why should the private sector pay for the benefits?

Chairman MURKOWSKI [continuing]. Did not address the question that is before us here today. That question is that for 17 percent of the veterans in this country, the private sector is taking a tax deduction and that deduction basically benefits the rest of the private insurance system.

Mr. BRIGGS. Yes, sir, it does.

Chairman MURKOWSKI. That is not necessarily the way the insurance underwriters designed their system. You have taken it in account, it lowers the cost for the private sector.

Mr. BRIGGS. Right.

Chairman MURKOWSKI. But it is certainly not an obligation of the Federal Government to provide that assistance to the private sector. It is an obligation of the Federal Government to provide assistance to the veterans, and the Government is going to maintain that obligation.

Ms. LEHNHARD. Mr. Chairman, I would say that we are not so much concerned about the cost of having to pay this. As was mentioned, it is the precedent of having to pay, employers having to pay for everything that is free that is provided to their employees. This is a tremendous precedent. It does not stop just with this Federal program. It affects all——

Chairman MURKOWSKI. But there is a contribution from the employer and employee and you say it is free.

Ms. LEHNHARD. And it is voluntary. If the employee does not want to make that contribution he does not have to. He might quite appropriately decide he wants to pay that part of the premium just in case he is traveling and he wants to go to a community hospital and he cannot get to a VA hospital or he wants to go to a specialist. That is the purpose of insurance; you just buy it if you want to insure against that risk.

Chairman MURKOWSKI. Sure.

Ms. LEHNHARD. I would also note that our other concern is——

Chairman MURKOWSKI. See, this is an optional concept.

Ms. LEHNHARD. It is optional on the part of the employee whether or not to pay that premium. That is the point we are making.

Chairman MURKOWSKI. Do you agree with the GAO statement that the cost of third-party reimbursements would be about a dollar for every $100 million in VA recoveries?

Ms. LEHNHARD. I am sorry, I am not familiar with those numbers.

Chairman MURKOWSKI. OK.

Mr. BRIGGS. I am not sure, sir, what the number is. But I would tend to think that the dollars are not the important factor here. The additional cost to the insurance industry is not very significant. However, the principle is very important, which is what I think my colleague was saying.

Chairman MURKOWSKI. I understand. We are talking about a significant change in principle here. I do not dispute that. But I would again ask you if you feel it is the Government's responsibility to provide savings at the taxpayers' expense for the benefit of the private sector? You have already answered that.

Ms. LEHNHARD. Mr. Chairman, to carry that analogy further, part B of Medicare is financed largely from general revenues. You could say along that analogy that the employers are being subsidized by the fact that the Government has chosen to fund part B of Medicare out of general revenues and that they should be offset for that.

It is the same type of principle. The Government has decided to provide a benefit and the system, and the Government has decided to provide a benefit, part B of Medicare, and the system as a whole benefits from that.

Chairman MURKOWSKI. Tell me, do you have any estimates of the administrative costs for claims processing, litigation, and reimbursing the VA under the proposed legislation? You said you did not have any estimate of what the cost savings were. So I assume you would not have any estimates of what the cost of administration——

Ms. LEHNHARD. No.

Chairman MURKOWSKI [continuing]. Administrating it was either?

Ms. LEHNHARD. Perhaps a better way for us to approach it is that the cost of those claims would be 3 to 4 times the cost of handling our other claims.

Chairman MURKOWSKI. Why do you say that?

Ms. LEHNHARD. Because they would not be subject to the same rules that our other subscribers are.

Chairman MURKOWSKI. You couldn't make the same rules for the VA?

Ms. LEHNHARD. No. For example, as I mentioned, one of the most fundamental things we are using now is putting subscribers at risk for complying for certain kinds of programs. We would have to pull those claims out, note that this subscriber should not get a higher deductible or co-pay. Those claims have to be handled manually.

Chairman MURKOWSKI. In other words working with the VA would be kind of like pulling teeth, in your opinion?

Ms. LEHNHARD. I think employers and insurance companies would say that.

Chairman MURKOWSKI. Well, it is kind of disappointing to think that, because we are seeking some kind of a relationship if we do get a law changed and get third party reimbursement. That is kind of an adversarial posture to start out on, which leads one to think that we would not exactly be working in harmony.

When you speak of savings to the private sector, are you referring to savings to the premium payers, employers, in some cases employees, or the health investors or the plan? Do the health insurers basically save anything?

Mr. BRIGGS. Well, the health, the health insurers themselves I think are neutral parties in the sense that they collect what they feel is adequate premiums to cover their claims and expenses in a very competitive environment. So I do not think that health insurers per se benefit. I think whoever pays the premium, whether the employers or employees, do benefit to some minor degree.

As we said before, the dollars are not huge. We are talking about small differences either way.

Chairman MURKOWSKI. Yes; but you do not have any idea what the dollars are?

Mr. BRIGGS. No, sir; we have seen the estimates which have been prepared. And I would not necessarily disagree with them. I do not know that they are wrong.

Chairman MURKOWSKI. Well, they are big dollars for the Government and for the committee to reflect on—$96 million to $284 million, in fiscal year 1982. I think you agree that as legislators we have the responsibility to consider that as a substantial benefit to the fiscal process that goes on around here.

Ms. LEHNHARD. I cannot take issue with those numbers. But I would note if this GAO report is correct, that up to 40 percent of all hospital days are unnecessary, and assuming that we would be able to apply the same tests of necessity in the VA that we do in community hospitals, you have got an immediate cut in those days. Because I doubt that the cost assumptions took into account that there might be unnecessary days.

Chairman MURKOWSKI. We are joined by Senator Alan Simpson, the immediate past chairman of the Veterans' Affairs Committee. It is a pleasure to welcome you here.

We have debated a good deal on the question of third-party reimbursements. We presently have representatives before us from the private insurers. We have heard testimony with regard to their position, the realities of what might be saved, and the likelihood of the insurer and the VA working together cooperatively for the fiscal interests of the budgetary process and the potential savings.

I guess what we derived was that there is a potential savings in effect at the taxpayers expense in the sense that the contributions from an employer or employee for 17 or 18 percent of the veterans when applied to the recipients in a health insurance program, receive the benefits of that contribution from veterans, even though there is no chargeback on it for services rendered to the veteran, necessarily, because the veteran has the alternative of the VA system.

With that bureaucratic explanation, if you care to make a statement or defend yourself, why, it would be appropriate.

Senator SIMPSON. No. Mr. Chairman, I just want to thank you for pursuing the issues that we had pursued a lot before, means test activity and third-party reimbursement feature. I have not had the benefit of reading the testimony. And I will because it is an interest of mine.

I still think that there are ways that could be reflected as savings to the taxpayer in there. And I appreciate your pursuing it.

Just wanted to drop by and support you and tell you I think you are doing a great job as chairman of the Veterans' Affairs Committee. It is a tough one because, you know, you just get hammered on, that's all. Some have said, "Simpson, since you left the chairmanship you have been making outrageous statements." And they really have been deep in my bosom, I must admit. But they were not made as antiveteran statements. They are made as realistic statements that somewhere in a time of limited resources you have to recognize that we must take care of the service-connected disabled veteran and then get down to priorities on those who served less than 6 months and never left the United States. And that is the way it is.

That is not an antiveteran statement. It is a prorealistic statement. The sooner we get to reality on that we won't have to tap the Treasury for $28 billion a year.

Now I am going to get out.

Chairman MURKOWSKI. Just a little over $27 billion.

Senator SIMPSON. $27 billion. Well, anyway, thank you.

Chairman MURKOWSKI. Thank you for your statement. I know it came from below the heart.

Senator SIMPSON. Below the belt? Oh, heart. Oh.

Well, I better get out of here before I get in trouble.

Chairman MURKOWSKI. Before we both get in trouble.

[The prepared statement of Hon. Alan K. Simpson, a U.S. Senator from the State of Wyoming, follows:]

PREPARED STATEMENT OF HON. ALAN K. SIMPSON, A U.S. SENATOR FROM THE STATE OF WYOMING

Mr. Chairman:

Today's hearing is essential as we consider implementation of reforms in the Veterans' Administration health-care policies. The present system of benefits and services is coming under increasing strain as the veteran population grows older and is in greater need of health care. In the next several years our World War II veterans will continue to reach age 65 and thus become eligible for VA medical care for both service-connected disabilities and non-service-connected disabilities. This will place a tremendous stress upon the VA health-care system which must be remedied. Enactment of the "means test" proposal, which would apply only to non-service-connected veterans, will provide a screening mechanism to assure that the VA health-care resources are targeted to those most in need. Additionally, the means test will result in a lower rate of growth in the VA medical care system and the construction budgets.

Also of great importance is the policy change calling for authority for the United States to collect the cost of medical care furnished by the Veterans' Administration to veterans with no service-connected disabilities - to the extent that they have health insurance or similar contracts or rights with respect to such care. This third party reimbursement concept is projected to save the United States millions of dollars by allowing recovery from the third party insurer. The General Accounting Office has estimated that if similar legislation had been in effect in fiscal year 1982 the Government could have recovered at least $98 million to $284 million from private health insurance with minimal impact on health insurance premiums paid by the veteran.

Concepts such as the means test and the third party reimbursement are certainly not anti-veteran as some opponents of the measure would suggest. Rather they are pro-veteran because they are pro-reality. The Federal Government simply does not have the luxury of continuing "business as usual" while ignoring the huge Federal budget deficit. This harsh economic reality and the need to bring about a spending reduction while providing the best possible services for the taxpayers dollar call for tough decisions and policy reform. The means test and third party reimbursement proposals will help achieve both of these important goals. I appreciate the interest of the Veterans' Administration, the veterans' service organizations, and the various parties from the private sector who have arranged to testify before the committee today and previously so that we may obtain their opinions on these very important policy considerations.

Thank you, Mr. Chairman, for granting me this opportunity to make these brief remarks. I would like to add my appreciation and admiration for the fine and responsible work you are doing on behalf of the veterans of our country in your capacity as Chairman of this committee.

Mr. **Briggs**. Mr. Chairman, can I make one more comment?

Chairman **Murkowski**. Surely, Mr. Briggs.

Mr. **Briggs**. One of the things that I think was considered back in 1980 at a similar hearing was this same question. And at that time, as I recall, the committee concluded that there really was not much validity to this idea that the third-party payer should reimburse the VA.

And I think at that time the statement was made that if indeed veterans who were unable to pay for their care were the only ones admitted that the whole question was moot because people who have insurance indeed can pay for their care and should be sent to community hospitals.

And that was, I think, the conclusion reached at that time. And it seems to me it is still the conclusion that should be reached now. If people have insurance they should be going to community hospitals.

I might point out that as I understand it the veterans' hospitals are going to be faced with a substantial increase in older veterans who will need care. They will need the facilities for those people.

In the meantime, the community hospitals, because of cost containment measures which have been implemented, are short of patients and, in fact, they have a lot of vacancies.

Therefore, to drive people to go to VA hospitals would just worsen the situation for both of them.

Chairman **Murkowski**. Your point is well taken. I mean, it just depends on which point of view you are looking at. The recommendations by you both have been made and will be noted and given consideration. You represent a point of view that is appropriate for your organizations. I am not the least bit surprised at where you are coming from.

As far as the chairman is concerned, why, I think I have indicated my concern over the potential savings that have been indicated by the appropriate Government agencies that are reflecting on what the savings might be. Frankly, I cannot see why it is not within the capacity of the systems to work in a cooperative manner, in spite of the VA having probably a little less flexibility than the private sector, simply because the private sector has to have more, that the VA system could not be changed to accommodate a high degree of efficient billing for coverage such as we are discussing today.

But that will be something that will be addressed by my colleagues in their collected wisdom. Somebody suggested the wisdom of the organization. And we will see what comes out of it.

We appreciate your willingness to testify.

Ms. **Lehnhard**. Thank you, Mr. Chairman.

Chairman **Murkowski**. We look forward to your continued cooperation.

[The prepared statement of Philip Briggs, executive vice president, Metropolitan Life Insurance Co., and representative of the Health Insurance Association of America, Washington, DC; the Blue Cross and Blue Shield Association's and the Health Insurance Association of America's responses to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs; an April 24, 1985, and an April 26, 1985, letter to Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs; and a May 2, 1985, letter to Ms. Mary Nell Lehnhard, office of government relations, Blue Cross and Blue Shield Association, follow:]

PREPARED STATEMENT OF PHILIP BRIGGS, EXECUTIVE VICE PRESIDENT, METROPOLITAN LIFE INSURANCE COMPANY AND REPRESENTATIVE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

My name is Philip Briggs. I am Executive Vice President of Metropolitan Life Insurance Company. I appear today on behalf of the Health Insurance Association of America, a trade association representing some 335 insurance companies. Our members write over 85 percent of the health insurance provided by insurance companies in this country.

We appreciate the opportunity to provide our views again on a proposal that would allow the Federal Government to recover the costs of medical care provided to veterans with non-service-connected disabilities to the extent that such veterans have health insurance. The proposal would prevent insurance companies from continuing to use clauses in insurance contracts which exclude payment for care provided by government health care facilities which veterans may obtain without cost. These exclusionary clauses exist because insurance pays only for actual expense (loss) incurred and for which there exists a legal obligation of payment in the absence of insurance.

This issue has been debated several times in Congress and in each instance it has been overwhelmingly rejected. The reasons that led to rejection of this proposal in past Congresses are just as valid today.

In fact, the issue was thought to have been resolved when Congress enacted the Veterans' Administration Health Care

Amendments of 1980 (Public Law 96-330). Under that law, veterans with non-service-connected disabilities continue to be entitled to care without cost in VA hospitals if they are unable to defray necessary expenses. However, Congress stipulated that such veterans' assertions of inability to pay would be presumed valid only if the veterans were receiving Medicaid or a VA pension. The concept that insured veterans might also be admitted for care of non-service-connected disabilities, and the Veterans' Administration would be given authority to recover costs from insurance carriers, was rejected.

The Conference Report on the legislation which became Public Law 96-330 is explicit on this point:

> The Committees also believe that any attempt to provide such authority to the VA to collect from such insurers for such services and to reduce the VA's appropriations in conjunction with such authority would significantly disrupt VA health care efforts and would ultimately prove futile or largely futile. Thus, the Committees have determined that the provision in the compromise agreement which would generally allow the VA to determine if a veteran has valid health insurance that would basically cover the cost of care and, if

so, to direct such veteran to a non-VA facility, is the more appropriate response to concerns about individual veterans receiving care from the VA where the cost should be borne by a health insurance carrier.

If the VA followed this practice directed by Congress then the question of recovery of costs from insurers would be moot.

Referral of insured veterans to non-VA facilities for care of non-service-connected disabilities made sense in 1980, and the arguments for this procedure are even more cogent now. There is great concern that the increase in the number of veterans over age 65, who are eligible for free care, threatens to nearly triple the demands on the VA health care system in the next 15 years. Construction costs and expenditures to expand the system to meet the increased demand will be substantial. At the same time, because of various cost containment measures in the private sector, community hospitals are experiencing significant declines in occupancy rates. If it has not done so, the Veterans' Administration should take immediate action to implement procedures to refer insured veterans to non-VA hospitals for treatment of non-service-connected disabilities. Legislation which would give the VA an incentive to increase, rather than decrease, its patient load would be counterproductive.

Not only would the present proposal run counter to the need to constrain the growth of the VA hospital system, but there are also some fundamental insurance principles that we believe require rejection of this proposal as an arbitrary and unwarranted abuse of governmental power.

Insurance contracts exclude payment for free entitlement care in VA and other government hospitals because the patient incurs no liability or charge. Health insurance is made available to provide the insured with protection against financial loss from hospital and medical charges for which he is liable. Since no charges are imposed on those qualified to receive VA health care, the patient incurs no loss and thus no reason or justification for insurance coverage exists. It is fundamentally wrong for the Government by fiat to mandate insurers to pay for care obtained without cost when no loss has been sustained by its insured.

We do not believe that the Government can legally mandate that insurance contracts reimburse for free care provided by Government hospitals that was not contractually agreed to between the parties to the contract. In essense, the insurer has agreed by contract to reimburse the insured for a loss (i.e., hospital and medical charges). The Government, not a party to the contract, has no constitutional right to infringe on that contract by demanding payment from the insurer when no contractual obligation exists to pay. No constitutional basis exists that allows the Government to take private property by this arbitrary means.

This proposal, if permitted, would result in higher health insurance premiums and administrative costs. These added costs would be principally borne by employers, who are the primary source of insurance benefits for employed population. Premiums do not now reflect any claims for VA health care because, as indicated above, this care is excluded from insurance coverage. Insurers reap no extra benefit or profit from this exclusion because insurance premium rates are calculated to reflect actual claims experience and utilization.

Premium increases for employer policyholders would vary. Employers near a VA hospital or those with many employees who are veterans would likely incur higher costs and pay higher premiums.

The proposal also runs counter to national efforts to control and reduce health care costs through reduction in the length of hospital stays, use of less costly alternatives to hospital care, and elimination of duplicative or unnecessary services. It appears unlikely that insurers would be permitted to engage in utilization review of VA hospital procedures and practices to control unnecessary costs and services, as carriers do in the private sector to protect policyholders' interests. Such practices include preadmission review and certification, establishment of appropriate length of stay prior to admission, concurrent review of utilization, postadmission audits to verify the propriety of services, and second opinions for elective surgery. We believe it is patently unfair to require insurers to reimburse VA hospitals for care they provide insureds without subjecting these hospitals to the same health care cost control measures that are required of private hospitals. Without effective utilization review, insurers would have no assurance that VA hospital admission was proper or that services were reasonably necessary in light of accepted medical practice. Full reimbursement of costs without such reviews, audits and other cost containment measures provides no assurance that services were delivered efficiently. We have a responsibility to our policyholders to control length of stays and treatment, which are known to be considerably longer and more extensive in VA hospitals.

Several potential problems also exist with VA hospital billing and accounting procedures. These problems could substantially raise administrative costs for both the VA and private insurers, since new procedures and methods of payment would be required and new personnel would be needed to handle this added system of claims administration. These additional costs would be passed on to taxpayers and policyholders.

Private insurers would expect the VA to use the national uniform billing form (UB-82), including all information pertaining to the patient, the insured, the employer and the policyholder. Insurers would need information on the principal and other diagnoses and surgical procedures, properly coded, and patient history and physical information when appropriate in order to pay the claim.

Insurers would also expect VA hospitals to follow established coordination of benefit principles when determining which carrier is primary when more than one is involved. In addition, VA facilities would be expected to forward on to secondary payers copies of the explanation of benefits.

Insurers would further expect the VA to distinguish professional from hospital charges. In cases when there are separate policies for medical and hospital benefits, insurers would need to receive separate bills, one for the professional component and one for the hospital component of the stay.

Specific detailed information on charges and services rendered is necessary to protect the interests of policyholders and restrain costs for unnecessary services and procedures. Billings received from the VA would have to be sufficient to verify that the charges are proper and that the services were actually rendered.

Since insurers would not be allowed to apply copayment and deductible provisions of their policies, this would have a significant impact on claims handling procedures. This would mean that VA hospital claims would have to be handled on a manual basis, because each one would require that extra contractual exceptions be made to the claims payment process.

The administrative costs to the VA, in adjusting its procedures to comply with requests for payment information, might significantly offset any potential recoveries received by the Government.

There are vast discrepancies in estimates of just how much might be recouped by the Government under this proposal. There is no reliable evidence indicating how many veterans seeking VA care have private health insurance. It is widely assumed by veterans organizations that most veterans using VA hospitals are not currently covered by insurance. Consequently, it is likely that the amounts which could be collected under the proposal would be small.

Moreover, working out the procedures to deal with the payment problems described earlier, and the likelihood of prolonged litigation to test the legality of the proposed approach, would delay any recoveries.

We recognize and sympathize with the hard decisions facing Congress in its efforts to reduce the federal deficit, and we know this proposal appears at first blush as an easy way to help solve budgetary problems, but we feel it is an extremely dangerous precedent fraught with problems far greater than any potential benefits.

The principal objection to this proposal is that it would violate the basic principle of insurance that requires loss as a basis for insurance protection. Since a patient who qualifies for care in a VA facility has no legal obligation to pay for care, it is patently wrong to impose on insurers an obligation to reimburse the Government for that care. No insurance situation exists. The Government would wrongfully be obtaining private sector funds to pay for a public responsibility. This is a dangerous precedent that could be stretched to permit the Government to force the private sector to pay for services provided by other public programs. We believe this proposal is unconstitutional, inequitable, inefficient and in violation of basic principles of insurance.

We urge the Congress to reject this effort, cloaked in the guise of budgetary reform, to transfer to insurers, and indirectly their policyholders, the responsibility for providing free care in VA health care facilities.

RESPONSE OF BLUE CROSS AND BLUE SHIELD ASSOCIATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. What do you estimate the annual costs of handling VA claims would be for Blue Cross and Blue Shield Plans?

Answer 1. As indicated in our June 20, 1985 testimony before the Committee, our opposition to the third-party liability legislation is based not on its costs for administration or benefits, but rather because it violates the principle of insurance and the protection of the Fifth Amendment of the Constitution, and because it shifts financial obligations to the private sector without the safeguards needed to contain health care cost increases. Nevertheless, Blue Cross and Blue Shield Plans would incur additional administrative costs if the proposal were enacted. We are unable to provide a definitive estimate of these costs because of time constraints and the lack of operational details such as the exact form and content of VA billings and the extent to which claims review would be needed. However, by making certain assumptions, we can explore the general magnitude of these costs.

To explore this question, we believe it is reasonable to consider the average costs that Plans incur to process non-VA claims, the additional medical review costs that would be incurred for VA claims, and the first-year start-up costs that would be required if the legislation were enacted. Using this approach, we estimate that the total three-year Blue Cross and Blue Shield Plan administrative costs under the legislation would be roughly $39 million. Our detailed assumptions and calculations are as follows:

The first step is to apply current Blue Cross and Blue Shield administrative cost and marketshare factors to an estimate of VA recoveries.

	FY 1986	FY 1987	FY 1988
Budget Cmte's total VA third-party recovery estimates[1]	$162,000,000	$392,000,000	$472,000,000
Blue Cross and Blue Shield share of covered veterans (assumed to equal 1984 market share of general population)	x 33%	x 33%	x 33%
Blue Cross and Blue Shield payments	$53,460,000	$129,360,000	$155,760,000
Blue Cross and Blue Shield 1984 average administrative cost as a percent of payments	x 8.8%	x 8.8%	x 8.8%
Blue Cross and Blue Shield total administrative costs	$4,704,000	$11,384,000	$13,707,000

Note: Dollar amounts rounded to nearest thousand.

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1. Source: U.S. Senate, Committee on the Budget, First Concurrent Resolution on the Budget, FY 1986. Report to Accompany S. Con. Res. 32, S. Report 99-15, March 20,

The foregoing calculation omits the additional costs that would be incurred to handle VA claims. Plans would incur start-up costs for familiarizing each of VA's 172 hospitals and 226 outpatient clinics with our payment policies and billing procedures, for computer program alterations to process VA claims, for inquiries from our subscribers who are covered veterans, and for expenses to educate our accounts about the need for premium increases to comply with the third-party liability legislation. We are unable to calculate the approximate costs of these tasks. Instead, we believe it is reasonable to assume that each of the 86 Blue Cross and Blue Shield Plans will need to be involved in start-up, and that our Plans will incur start-up expenses averaging $30,000 per Plan. Under this assumption, our Plans' total start-up costs would be $30,000 multiplied by 86, which equals $2,580,000.

In addition to start-up costs, the administrative cost for each VA claim is likely to be greater-than-average due to the need for stringent medical and utilization review. Post-admission review appears to be permitted by the legislation. A GAO draft report, "Better Patient Management Could Reduce Length of Stay in VA Hospitals" estimates that 31% to 43% of all VA medical and surgical inpatient hospital days are unnecessary. GAO found that internal VA medical review procedures need substantial improvement; for example, none of 15 surveyed VA hospitals had an internal review program that met American Hospital Association standards. GAO's estimate is conservative because it excluded longer-stay "intermediate medicine" and psychiatric diagnoses, which have less standardized treatments and thus greater potential for unnecessary days. Given this very high rate of unnecessary days, Blue Cross and Blue Shield Plans may be compelled to review 100% of VA inpatient claims and a greater-than-average percentage of outpatient claims. Under this assumption, medical review costs would probably be of the following magnitude.

(cont.)
1985, p. 130.

VA estimate of FY 1986 inpatient episodes[2]	1,280,379
VA estimate of eligible non-service connected veterans (as % of all eligibles)[3]	X 67.6%
Estimate of FY 1986 non-service connected inpatient episodes	865,536
GAO estimate of non-service-connected veterans with private insurance (as % of all non-service vets)[4]	X 18%
Estimated total FY 1986 insured inpatient episodes	155,796
Blue Cross and Blue Shield share of insured veterans (assumed to equal market share)	X 33%
Blue Cross and Blue Shield FY 1986 number of inpatient episodes	51,413
Typical cost of post-admission medical review per episode (Wisconsin Peer Review Organization)	X $42.93
Blue Cross and Blue Shield annual cost for 100% review of VA inpatient episodes	$2,207,000

Note: Total dollars rounded to nearest thousand.

Note that total medical review costs would increase in later years, assuming 100% review were maintained, due to the expected increased number of episodes, but would decrease if less than 100% of cases were reviewed. Taken alone, the $2,207,000 figure for inpatient medical review costs would be a slight overestimation of total inpatient review costs if it were added to the "average" assumed administrative costs projected by our first calculation. This would be because the "average" calculation includes a factor of unknown amount for the average level of inpatient review done by our Plans for non-VA providers. However, we assume that our Plans would also conduct medical review of VA outpatient services at a greater-than-average level. We are not able to project the cost of this expanded outpatient review, thus those costs are excluded in our calculations. We will assume that the inpatient review cost overestimation would be cancelled out by the outpatient review cost underestimation. Thus, we believe that the assumed inpatient medical review costs can be added to the assumed "average" administrative costs to produce a total cost figure.

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[2] Source: Veterans Administration, office of Budget and Finance, "Medical Programs, Fiscal Year 1986," Volume II, p. 5-37.

[3] Source: Ibid., p. 5-7.

[4] Comptroller General, U.S. General Accounting Office, "Legislation to Authorize VA Recoveries From Private Health Insurance Would Result in Substantial Savings," February 26, 1985, p. 13

Based on the above assumptions and calculations, total administrative costs would be expected to be of the following magnitude.

	FY 1986	FY 1987	FY 1988
Assumed costs if costs for VA are equal to average for all other claims	$4,704,000	$11,384,000	$13,707,000
Assumed costs for start-up	+ 2,580,000	+ -0-	+ -0-
Assumed costs for 100% medical review of inpatient episodes	+ $2,207,000	+ $2,207,000	+ $2,207,000
Assumed total costs	$9,491,000	$13,591,000	$15,914,000

Note: Dollars rounded to nearest thousand.

Thus, the total three-year Blue Cross and Blue Shield Plan administrative costs under the legislation would be on the order of magnitude of roughly $39 million in current dollars. This figure is not a definitive estimate, as explained earlier, but merely a general approximation. Certainly other assumptions could be used to produce different results. Regardless of the administrative costs that the private sector may incur under the proposal, we believe it is important to note that these costs, plus the additional VA implementation and ongoing administrative costs, will be incurred solely to change the responsibility for payment for care rather than to improve the efficiency of the VA system, the quality of care rendered, or the level of benefits received by veterans.

Q2. Do Blue Cross/Blue Shield Plans intend to comply with the third-party legislation if it is enacted and the VA seeks recoveries or will their position be to pay only if ordered by a court to do so?

A. The Blue Cross and Blue Shield Association has been provided a legal opinion by the law firm of Miller & Chevalier, Chartered, which concludes that the VA proposal is unconstitutional. If legislation were enacted and the VA sought to recover charges from Blue Cross and Blue Shield Plans for otherwise free care provided to veterans with non-service-connected disabilities, we and our 86 independent member Plans operating in the U.S. would be forced to seriously consider, individually or collectively, testing the legality of the action through the judicial system. Our review of this matter would take into account our firm belief that the VA proposal is unconstitutional as currently drafted.

RESPONSE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. On page 8 of your testimony, you discuss concerns about how VA claims would have to be handled by insurance carriers.

A. If, as you note, VA claims would have to be handled separately, why wouldn't companies be able to develop separate computer programs to deal with VA claims?

B. What do you estimate the annual, industry-wide administrative costs of handling VA claims would be?

Answers 1A and 1B.

The second paragraph on page 8 of Mr. Briggs' written statement appears to have prompted your first question. This was deleted in his oral testimony because we learned, after submitting the prepared testimony, that the most recent proposal before the Committee would allow insurance companies to impose copayments and deductibles. If the VA were able to produce bills like other hospitals (e.g. separating medical from hospital costs, providing copies of explanation of benefits to secondary carriers, etc.), there should not be a need for special handling.

If special handling were required, computerized claims processing would not be practical. There are nearly 340 member companies in the Health Insurance Association. Hundreds of additional small insurance companies, plus over 60 Blue Cross/Blue Shield Plans, provide health insurance. No one company has any significant amount of business that includes veterans that might use Veterans' Administration facilities. Since each of these companies has developed its own unique claims handling procedures, each would have to develop its own unique computer programs. It is unlikely that many, if any, companies would find it cost effective to automate their handling of VA claims, given their small volume.

It is not possible to estimate the annual, industry-wide administrative costs of handling VA claims. We would first need a definite proposal that details the explicit administrative procedures that the VA would follow in submitting claims. An accurate estimate of the total number of claims the VA would be expected to submit to the insurance industry would also be needed. An estimate of the extent to which the entire process of handling a VA claim differed from the companies' existing claims handling procedure would then have to be made.

Question 2. On page 8 of your testimony, you state, "There is no reliable evidence indicating how many veterans seeking VA care have private health insurance." In your view, why are the data in the recent GAO report on third-party reimbursement not reliable?

Answer 2.

> Your second question relates to the recent GAO report. Although this report appears to support our contention that relatively few veterans who receive care for non-service-connected disabilities actually have private insurance coverage, we question whether even its 18 percent figure gives a true picture. The "limited effort" to validate the questionnaire and the number of incorrect responses from veterans shown in the validation, as reported in Appendix II of the report, raise questions about the results. Further, the questionnaire elicited information as to the existence--not the comprehensiveness--of coverage. Consequently, the projection of the potential recovery by VA, based on the assumption of full coverage, is overstated.

Question 3. On page 9 of your statement, you note "the likelihood of prolonged litigation to test the legality" of third-party reimbursement legislation. Do HIAA members intend to comply with the third-party legislation if it is enacted and the VA seeks recoveries or will their position be to pay only if ordered by a court to do so?

Answer 3.

> In answer to your third question, HIAA and its member companies would analyze the legislation, if enacted, to determine whether or not compliance was possible under contract provisions and constitutional principles. We have serious reservations as to whether reimbursement would be possible, but that judgement would have to await review of enacted legislation.

Veterans
Administration

APR 24 1985

In Reply Refer To:

021:REB

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Pursuant to your request of April 15, 1985, enclosed please find a white paper on the constitutionality of proposed legislation to void exclusionary clauses in health insurance policies.

Please let me know if you have any further questions on this subject.

Sincerely yours,

Donald L Ivers

DONALD L. IVERS
General Counsel

Enclosure

WHITE PAPER

CONSTITUTIONALITY
OF
PROPOSED LEGISLATION VOIDING EXCLUSIONARY CLAUSES
IN HEALTH INSURANCE POLICIES

(1985)

CONSTITUTIONALITY OF PROPOSED LEGISLATION VOIDING EXCLUSIONARY CLAUSES IN HEALTH INSURANCE POLICIES

The Veterans Administration has proposed legislation to amend section 629 of title 38, United States Code, to authorize the United States to recover the cost of hospital, nursing home, or outpatient medical care furnished or paid for by the VA to veterans with no service-connected disabilities to the extent of any coverage under a private health insurance policy or similar contract or plan.

Section 629 is the current authority for the VA to collect its costs under no-fault, workers' compensation, and crime-victims' statutes. The proposed legislation would add private health insurance policies to these sources of recovery and would affect policies entered into, renewed, or modified after the first day of the fourth month following the month of enactment.

Commercial insurance companies were reimbursing the VA for these costs prior to the adverse decision in United States v. St. Paul Mercury Indem. Co., 238 F.2d 594 (8th Cir. 1956). The court held in that case that, since the veteran was entitled to care at the VA without cost, the requirement under the insurance policy to pay only for expenses actually incurred obviated the company's payment obligation. A more recent attempt at reimbursement met a similar fate. See United States v. Metropolitan Life Ins. Co., 683 F.2d 1250 (9th Cir. 1982). These cases demonstrate the need for legislation to overcome the clauses in policies that prevent VA recoveries.

Due Process of Law

As early as 1970, the question of the constitutionality of such legislation was entertained. In a February 6, 1970, letter to the Director, Bureau of the Budget, the Deputy Attorney General of the United States expressed some reservation as to whether the obstacles to reimbursement could be overcome by regulation, but left no doubt that a legislatively established program would be constitutional, provided it was drafted so as to avoid affecting existing contracts:

> However, we believe that Congress could accomplish this result by statute. Of course, any attempt to alter existing contractual obligations would raise a serious problem of deprivation of due process of law. See Lynch v. United States, 292 U.S. 571 (1934); Pennsylvania Coal Co. v. Mahon, 260 U.S. 393 (1922). But Congress could provide, in effect, that contracts entered into subsequent to the effective date of the statute may not exclude from coverage hospital care furnished by the Veterans Administration for non-service-connected disabilities. Clearly, such legislation would not raise any constitutional problems on due process grounds. As to the constitutional basis for such a regulation of the terms of private contracts, we believe that as part of its authority to provide veterans' benefits Congress may enact necessary and proper legislation to see that such benefits accrue only to the intended recipients and thus to protect the public treasury from windfall gains by insurance carriers. See United States v. Standard Oil Co., 332 U.S. 301 314-15 (1947); United States v. Jones, 264 F. Supp. 11, 15 (E.D. Va. 1967). Of course, the proposed legislation might also be justified as a regulation of a business in or affecting interstate commerce, see Maryland v. Wirtz, 392 U.S. 183 (1968); United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944), if further constitutional support were thought necessary.

Subsequent communications from the Department of Justice have echoed this opinion.

In its February 26, 1985, report entitled "Legislation To Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings," the General Accounting Office concluded that application of legislation such as S. 759 would not violate due process. In support of its opinion, GAO quoted an April 1979 letter to the Chairman, Senate Veterans' Affairs Committee, from the Assistant Attorney General, who in commenting on S. 759 discounted the argument that the legislation would have a constitutionally prohibited retroactive effect:

> The retrospective aspects of this bill therefore are neither "manifestly unjust" nor "particularly harsh and oppressive"; to the contrary everything has been done to protect the insurance carriers' reasonable interest.

GAO Report, p. 43

Nevertheless, it has been argued that a requirement for the elimination of these exclusions from "guaranteed renewable" policies (those policies for which the carrier's only option, if the insured chooses to renew, is to modify the applicable premium) violates the due process clause of the fifth amendment of the Constitution. This position appears to be based upon the decision by the Court of Appeals of New York in Health Ins. Ass'n. of America v. Harnett, 44 N.Y. 2d 302, 405 N.Y.S. 2d 634 (1978). There, the court held that a recently enacted State statute mandating the inclusion of maternity care coverage in health and accident insurance policies was unconstitutional as applied to guaranteed renewable policies. The court based its decision on article I, section 10, of the United States Constitution which prohibits the states from passing any law which would impair the obligations of contracts. However, the contracts clause has no application to the Federal Government. Century Arms, Inc. v. Kennedy, 323 F. Supp. 1002 (D. Vt. 1971), aff'd., 449 F.2d 1306 (2d Cir. 1971), cert. den., 405 U.S. 1065 (1972).

Reliance upon the Harnett case is therefore inappropriate. Indeed, in that case, the court specifically held that the statute under challenge complied with due process of law as required by the fourteenth amendment. Thus, the case lends support to the position that the proposed legislation is constitutional under the due process clause of the fifth amendment. See also St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531 (1978); Hewlett & Packard Co. v. Barnes, et al., 571 F.2d 502 (9th. Cir. 1978); and Insurers' Action Council, Inc. v. Heaton, 423 F. Supp. 921 (D. Minn. 1976).

McCarran-Ferguson Act

While not a constitutional issue, it has also been argued that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, generally leaving to the States the regulation of insurance, would conflict with the proposed exclusionary clause legislation. However, section 1012(b) of the Act excepts Federal laws which specifically relate to the business of insurance. Congress did not grant the States an exclusive right over the regulation of the business of insurance:

> States have power, under the Act, to regulate the insurance business within reasonable bounds, as limited by United States Supreme Court decisions, and within the limits laid down by Congress in the Act . . . .
>
> The Act did not, in common parlance, grant the states any power, but left them with the indigenous power they then possessed unaffected

> by reason of the commerce clause of the United States Constitution except to the extent provided in the Act . . . .
>
> . . . .
>
> As a general rule, where there is an applicable state statute, federal legislation does not apply to the insurance business under the McCarran-Ferguson Act (15 USC §§ 1011-1015), unless the federal legislation invalidates, impairs, or supersedes the applicable state statute . . . .

21 L. Ed. 2d 950, 951 (citations omitted)

There is, therefore, no conflict between the proposal and the McCarran-Ferguson Act.

Eminent Domain

Finally, objections to exclusionary clause legislation have been lodged in terms of it violating the "basic principle" that insurance should not have to cover charges for which the policyholder has no legal obligation to pay.

The most recent formulation of this argument is that the proposed legislation would work an unconstitutional "taking" of property for a public purpose without just compensation in violation of the fifth amendment's limitation on the Government's power of eminent domain. The argument totally ignores the fact that veteran policyholders are being compensated by receiving medical care in a VA medical facility. The legislation would merely require the insurers to pay for the cost of care provided to their policyholders; care for which premiums have been paid. The fact that the Government does not choose to charge and collect from the veterans themselves for deductibles, co-payments, or other portions of medical bills not covered by insurance gives no cause for complaint by the insurers and certainly none by the veterans.

In this regard, the proposed legislation is similar to the Federal Medical Care Recovery Act (FMCRA) and 38 U.S.C. § 629, both of which create an independent right in the Government to collect its medical care costs in certain circumstances despite the lack of an obligation to pay on the part of the recipient of the care. Both have been upheld by the courts. United States v. Jones, 264 F. Supp. 11 (E.D. Va. 1967) (FMCRA held constitutional); United States v. State Farm Insurance Company, 599 F. Supp. 441 (E.D. Mich. 1984) (Section 629 preempts state no-fault law to the extent it would prevent reimbursement to VA).

The analogy to the FMCRA is an apt one. The act was passed following the Supreme Court's decision in United States v. Standard Oil Co., 332 U.S. 301 (1946), where the Court held that, absent a statute, the Government could not recover its cost of treating a soldier injured as the result of another's negligence. In so holding, however, the Court made it clear both that Congress had the power to authorize such recoveries through legislation and that this power was not limited to the tort context, stating:

> For grounded though the argument is in analogies drawn from that field [tort], the issue comes down in final consequence to a question of federal fiscal policy, coupled with considerations concerning the need for and the appropriateness of means to be used in executing the policy sought to be established. The tort law analogy is brought forth, indeed, not to secure a new step forward in expanding the recognized area for applying settled principles of that law as such, or for creating new ones. It is advanced rather as the instrument for determining and establishing the federal fiscal and regulatory policies which the Government's executive arm thinks should prevail in a situation not covered by traditionally established liabilities.

> Whatever the merits of the policy, its conversion into law is a proper subject for congressional action, not for any creative power of ours. Congress, not this Court or the other federal courts, is the custodian of the national purse. By the same token it is the primary and most often the exclusive arbiter of federal fiscal affairs. And these comprehend, as we have said, securing the treasury or the government against financial losses however inflicted, including requiring reimbursement for injuries creating them, as well as filling the treasury itself.

332 U.S. at 314-315

After passage of the FMCRA, the U.S. District Court for the Eastern District of Virginia in United States v. Jones, supra, commented:

> It took Congress fifteen years to fill the gap occasioned by United States v. Standard Oil Co., 332 U.S. 301, 67 S.Ct. 1604, 91 L.Ed. 2067 (1947), wherein the Supreme Court ruled that only Congress had the power to create a parallel right of action to recover amounts expended for hospitalization by reason of injuries received as the result of negligence of a third party. To now hold that the Federal Medical Care Recovery Act is unconstitutional would, in effect, be tantamount to disregarding the language of the Supreme Court in its 1947 opinion heretofore mentioned.

264 F. Supp. at 14

Similarly, in United States v. State Farm Ins. Co., supra, the court had no difficulty in articulating a valid Federal purpose for the Government's pursuit of recovery under a no-fault policy pursuant to 38 U.S.C. § 629:

> Moreover, the Government's action is fashioned to prevent the insurance carrier from unjustly benefiting from the fortuitous circumstance of Mytty's veteran status. The Government has provided medical care and services to Mytty at a significant cost to the taxpayers. But for Mytty's status, State Farm would have been bound to pay for that care from the outset. The insurance premiums paid by Enio Mytty were assessed with a view toward the risk of an accident such as the one presented here. State Farm's failure to pay for the reasonable value of the services rendered by the VA has unjustly enriched the insurance carrier and significantly burdened the taxpayers. This is a classic case of unjust enrichment . . . .

599 F. Supp. at 446

Again, the February 1985 GAO report concluded that the absence of an obligation to pay on the part of the veteran is no obstacle to the Government's entitlement to reimbursement when the authorizing legislation gives the Government an independent Federal right of recovery.

Summary

There are no genuine constitutional issues raised by the proposed exclusionary clause legislation. Due process objections lodged against earlier versions of the proposal based upon possible retroactive effects have been met with provisions for assuring only prospective application of the legislation. There is no conflict with McCarran-Ferguson since the law would specifically relate to insurance. The eminent domain argument is essentially frivolous. Cases cited in support of the argument have been researched and capsulized in the attached appendix. They simply have no relevance to the issue of Federal authority to recover from private insurers the cost of care furnished to veterans. There is ample precedent in the cases upholding the FMCRA and 38 U.S.C. § 629 to support the conclusion that the proposed legislation would be found constitutional.

ROBERT E. BROYLES
Staff Attorney (021C1) Date: April 22, 1985

E. DOUGLAS BRADSHAW, Jr.
Deputy Assistant General Counsel (021B) Date: Apl 22, 1985

Appendix

Webb's Fabulous Pharmacies, Inc. v. Beckwith, 449 U.S. 155 (1980)

County's taking, pursuant to Florida law, of interest accruing on interpleader fund deposited in county court, was a taking in violation of the 5th amendment, applicable to the states through the 14th amendment, where there was a separate law that authorized a clerk's fee based upon the amount of the principal sum deposited, the deposited fund itself was private, and the deposit in the court's registry was required by State law if the depositor was to protect himself by filing the interpleader.

Penn Central Transp. Co., v. New York, 438 U.S. 104 (1978)

The Grand Central Terminal, owned by Penn Central Transportation Company, was designated an historic landmark. Thereafter, it was leased to UGP properties which planned to build a multistory office building over the terminal. The Landmarks Preservation Commission rejected these plans and suit followed.

The Supreme Court affirmed the lower court and held that, although the 5th amendment's prohibition against an unjust taking of private property without just compensation is applicable to the states through the 14th amendment, the Government may execute programs adversely affecting recognized economic values without such act being a "taking"; that the character of the action and nature and extent of the interference with property rights are focused upon rather than discrete segments; that diminution in property value alone cannot establish a taking nor regulation of individual landmarks; that although the Landmarks Law affects some landowners more than others, the preservation benefits the citizenry economically and improves the overall quality of city life; that this law is similar to zoning and merely prohibits occupying certain features of space while allowing use of the remainder; and that there is no interference with the present use of the property.

Goldblatt v. Town of Hempstead, 369 U.S. 590 (1962)

Suit to enforce an ordinance prohibiting excavations below 2 feet above maximum ground water level. The defendants, who were engaged in dredging and pit excavation, asserted that the ordinance was an unlawful taking of their property.

The Supreme Court affirmed the lower court's finding that the ordinance was a valid exercise of the town's police power under the fifth amendment to the U.S. Constitution.

Armstrong v. United States, 364 U.S. 40 (1960)

Unpaid materialmen whose supplies went into the construction of vessels for the Government which appropriated them upon the contractor's default were entitled to compensation under the fifth amendment. The Court of

Claims decision that it was a public work immune from materialmen's liens was reversed by the Supreme Court.

United States v. Causby, 328 U.S. 256 (1946)

An airport was leased to the Government which scheduled frequent flights of Army and Navy planes at a low altitude over a chicken farm, rendering it unsuitable for that use. The farmer, alleging an unconstitutional taking, obtained judgment in his favor in the Court of Claims. On appeal, the Supreme Court agreed with the finding of the Court of Claims that the frequent, low-level, flights were a direct and immediate interference with the enjoyment and use of the land, but reversed the award of damages and remanded the case for findings as to the permanency of the easement taken by the Government.

Hadacheck v. Sebastian, 239 U.S. 394 (1915)

Owner of brick making business was prohibited from operation after his property became annexed to the city of Los Angeles.

The Court held that the municipal ordinance enacted as a police measure did not take property without due process of law under the fifth Amendment to the U.S. Constitution.

Pennsylvania Coal Co. v. Mahon, 260 U.S. 393 (1922)

Land was sold subject to the right of mining coal upon which a residence was erected. A statute was subsequently passed which prohibited mining under such structures and the owners of the residence sued for an injunction to stop the mining operation. The Supreme Court of Pennsylvania found the statute a constitutional exercise of the State's police power, but the Supreme Court reversed, holding that the statute was unconstitutional as a taking of property (the right to mine coal) without due process of law.

Mugler v. Kansas, 123 U.S. 623 (1887)

Kansas enacted a law prohibiting the manufacture and sale of intoxicating liquors. The plaintiffs alleged that their buildings were erected for the manufacture of liquor before passage of the law and thereby became useless.

The Supreme Court held that a prohibition on the use of property that would injure the health, morals, or safety of the community is not an unlawful taking of property under the 14th amendment to the U.S. Constitution.

Pumpelly v. Green Bay & Miss. Canal Co., 80 U.S. (13 Wall.) 166 (1871)

A dam was built on a navigable stream raising its level and causing it to overflow and flood the land of another.

The Supreme Court held that the superinduced additions of water and earth effectually destroyed its usefulness and was a taking within the meaning of the Constitution.

United States v. United Services Automobile Assn., 431 F.2d 735 (5th Cir. 1970)

Suit was brought under medical payment provision of automobile policy for costs of medical expenses. The court interpreted policy to include the Government as a third party beneficiary.

GEICO v. United States, 376 F.2d 836 (4th Cir. 1967)

An Army officer's son was injured in an automobile accident. The tort feasor was uninsured but the son recovered under the no-fault policy of the automobile in which he was riding as a passenger. The insurer denied payment to the Government for medical expenses.

The court held that the Government's right to recover was based upon the policy provision that one entitled to recover from the uninsured third party is in turn entitled to payment as an insured.

United States v. Jackson, 572 F. Supp. 181 (W.D. Mich. 1983)

Suit under the Federal Medical Care Recovery Act (FMCRA) against automobile driver's no-fault insurance and the owner of a bar which allowed the tort feasor to become intoxicated.

Court held that FMCRA applies under circumstances creating a tort liability and under Michigan no-fault law, tort liability was extinguished.

The court also found that the Government was not a third party beneficiary to the no-fault policy in view of the express language of State law prohibiting recovery by the Federal Government.

NOTE: There was no Federal law such as 38 U.S.C. § 629 authorizing recovery in this case. The injured party was a seaman, not a veteran. Since then, United States v. State Farm Ins. Co., 599 F. Supp. 441 (E.D. Mich. 1984), which concerned a veteran, has upheld 38 U.S.C. § 629.

United States v. Allstate, 306 F. Supp. 1214 (N.D. Fla. 1969)

Suit was filed to recover medical expenses under an uninsured motorist policy of insurance. The court held that the Government was not an insured as defined in the policy, distinguishing Geico v. United States, 376 F.2d 836 (4th Cir. 1967), due to the express language of the policy which defined "insured" to include only the policyholder, relatives and residents of his household, and occupants of the policyholder's vehicle.

Office of Legislative and Intergovernmental Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

April 26, 1985

Hon. Frank H. Murkowski,
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D. C. 20510

Dear Senator Murkowski:

This letter responds to your request for this Department's views concerning the constitutionality of proposed legislation concerning third party reimbursement from private health insurers for care provided by the Veterans Administration in connection with non-service connected disabilities. As noted in the letter dated January 28, 1985 from Anthony C. Liotta to William J. Anderson, reproduced as Appendix VII to the Comptroller General's Report to Congress dated February 26, 1985 (the "Comptroller General's Report") concerning this legislation, the Department of Justice perceives no constitutional barrier to the proposed legislation, and generally affirms the legal analysis included in Chapter 4 of the Comptroller General's Report. Moreover, this Department on two prior occasions opined that Congress constitutionally may legislate to prohibit clauses in private health insurance policies excluding coverage for care provided at Veterans Administration hospitals for non-service connected disabilities. See letter dated April 14, 1979 to Hon. Alan Cranston, Chairman, Senate Committee on Veterans' Affairs, from Patricia M. Wald, Assistant Attorney General, Office of Legislative Affairs; letter dated June 11, 1973 to Paul H. O'Neill, Associate Director for Human and Community Affairs, Office of Management and Budget, from Robert G. Dixon, Jr., Assistant Attorney General, Office of Legal Counsel.

Having carefully reviewed the memorandum of law prepared by Miller & Chevalier for Blue Cross and Blue Shield Association enclosed with your letter, we strongly adhere to our view that the proposed legislation is constitutional. In particular, we disagree with Miller & Chevalier's conclusion that the proposed legislation would violate the guarantees of the Fifth Amendment of the Constitution against governmental appropriations of private property without just compensation. The Supreme Court has adopted a pragmatic, case-by-case approach to determining whether a particular governmental action constitutes a "taking" for purposes of the Fifth Amendment. It has described the appropriate analysis as follows:

> In engaging in these essentially ad hoc, factual inquiries, the Court's decisions have identified several factors that have particular significance. The economic impact of the regulation on the claimant and, particularly, the extent to which the regulation has interfered with distinct investment-backed expectations are, of course, relevant considerations. So, too, is the character of the governmental action. A "taking" may more readily be found when the interference with property can be characterized as a physical invasion by government than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good.

Penn Central Transportation Co. v. New York City, 438 U.S. 104, 124 (1978)(citations omitted). See also, e.g., Lorretto v. Teleprompter Manhattan CATV Corp., 458 U.S. 419 (1982) (generally endorsing balancing approach but adopting a per se rule for permanent physical occupations); Pruneyard Shopping Center v. Robins, 447 U.S. 74, 83 (1980); Kaiser Aetna v. United States, 444 U.S. 164, 174 (1979).

Applying this analysis, we think it clear that the legislation at issue here would not constitute a "taking." The legislation's economic impact on private insurers would be de minimus, and would not in any meaningful sense interfere with private insurers' "distinct investment-backed expectations." In this regard, it is significant that the proposed legislation is prospective only in that it prohibits exclusionary clauses only in insurance policies entered into, renewed or modified after its effective date. The proposed legislation does not prohibit insurance carriers from adjusting their premiums to take account of their new liability for care provided at Veterans Administration facilities. Based on the Comptroller General's analysis, there is no reason to believe that any such premium increases would be substantial, or that they would affect the demand for health insurance. *See* Comptroller General's Report at pp. 33-35. In short, there *is* no reason to believe that the ultimate economic impact of the proposed legislation on private insurers will be more than minimal.

Moreover, the proposed legislation does not involve any physical invasion by the government, and is, in our view, well within the government's power to regulate. Under current law, the taxpayers bear the cost of providing certain health care to veterans for non-service connected disabilities. As to veterans with health insurance, this government subsidy ultimately benefits either the health insurance carrier (if premiums are not lowered to take account of the free care available to veterans) or all policyholders (if premiums are lowered). Congress may reasonably determine that it is in the public interest to spread part of the cost of providing this health care among all persons (or all veterans) with health insurance in order to preclude either a windfall to the health insurance companies or a government financial benefit to nonveteran policyholders. To accomplish this objective, Congress may exercise its clear power to regulate insurance, *see* *United States* v. *South-Eastern Underwriters Association, et. al*, 322 U.S. 533 (1944), to require that all health insurance policies cover care provided at Veterans Administration facilities for non-service connected disabilities. In effect, Congress would be determining that all health insurance covering veterans must include coverage for certain care provided at Veterans Administration facilities, *i.e.*, that the Government will not pay the cost of providing certain health care for non-service connected disabilities to the extent that a veteran is covered by health insurance for the types of medical services at issue. We see no reason why Congress may not so regulate health insurance policies to ensure that a government benefit is not used to subsidize health insurance carriers or non-veteran policyholders.

We disagree with Miller & Chevalier's assertion that this proposed legislation is analogous to the Florida provision at issue in *Webb's Fabulous Pharmacies, Inc.* v. *Beckwith*, 449 U.S. 155 (1980), which authorized the clerk of a county court not only to charge a reasonable fee for services rendered, but also to appropriate for the government all interest earned on interpleaded funds deposited with him. As the Supreme Court noted, the Florida provision required a "forced contribution to general government revenues" for which the county could not offer any police power justification. 449 U.S. at 164. In contrast, the proposed legislation at issue here serves the legitimate legislative aim of providing health care to veterans in an economically efficient manner without imposing any unfair or unreasonable economic burden on insurance carriers. Far from "taking" property belonging to private parties, the proposed legislation simply determines how certain government subsidies will be allocated in the future. The proposed legislation operates in classic regulatory fashion in that it governs only future conduct, and allows private insurers (and all others affected) to adjust their behavior in light of the regulation.

For these reasons, nothing in the Miller & Chevalier memorandum of law causes us to change our prior opinion that the proposed legislation is constitutional.

Sincerely,

Phillip D. Brady
Acting Assistant Attorney General
Office of Legislative and
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May 2, 1985

Ms. Mary Nell Lehnhard
Office of Government Relations
Blue Cross and Blue Shield Association
1709 New York Avenue, NW
Washington, DC 20006

Veterans' Health Benefits

Dear Mary Nell:

We have reviewed the letter from Phillip D. Brady, Acting Assistant Attorney General, Office of Legislative and Intergovernmental Affairs, Department of Justice, dated April 26, 1985, to the Honorable Frank H. Murkowski, Chairman of the Senate Committee on Veterans' Affairs. Mr. Brady addresses, and rejects, arguments made in our letter to you, dated April 8, 1985, to the effect that certain proposed Veterans' health legislation is unconstitutional. This letter responds to the issues raised by Mr. Brady.

The letter from the Department of Justice handles the authorities in cursory fashion and cites general language from those cases which is not relevant to the circumstances of the proposed legislation. The Justice Department seeks refuge in the "case-by-case" approach and fails to deal with the evolving principle that the government violates the Fifth Amendment when it takes property from private parties without compensation in the course of carrying out one of its programs. We think that the Department's analysis is unpersuasive.

The Department of Justice rests most of its case on several arguments which are peripheral to the constitutional issue. In view of the extensive treatment of these issues in prior correspondence, we only will quote key conclusions from Mr. Brady's letter, in the order in which they appear, and offer a brief rebuttal:

1. The "legislation's economic impact on private insurers would be de miminus * * *."

   The General Accounting Office currently estimates a $300,000,000 annual recovery from insurers under the proposed legislation. This is not de miminus under any relevant standard.

2. "[T]he proposed legislation is prospective only * * *" and "[t]he proposed legislation does not prohibit the insurance carriers from adjusting their premiums to take account of their new liability * * *."

   This argument misses the point; the issue is whether the government illegally is taking the carriers' property without compensation, not whether the carriers may be able to pass the cost of the illegal taking onto some of their accounts. This argument would justify any illegal taking if the government could produce economic analysis indicating that the victims might be able to recover the additional costs in the form of price increases to their customers.

3. "* * * [T]he proposed legislation does not involve any physical invasion by the government * * *."

   Neither was there any physical invasion in the Webb's case, discussed by Mr. Brady, which struck down an unlawful taking by the State of Florida.

4. The health care subsidy afforded veterans "ultimately benefits either the health insurance carrier (if premiums are not lowered to take account of free care available to veterans) or all policyholders (if premiums are lowered)."

   This analysis again misses the point -- the subsidy benefits the veterans, who receive the free care. If Congress believes that the free care should be continued, the Congress should continue to provide the free care with tax revenues. If Congress believes that veterans should not be provided free health care, then the veterans should be made to pay. There is no basis, however, for making the carriers and pay for the obligation assumed by the government to provide veterans with free health care.

5. "We see no reason why Congress may not so regulate health insurance policies to ensure that a government benefit is not used to subsidize health insurance carriers or non-veteran policyholders."

This sentence unwittingly concedes the premise of our argument -- the purpose of the legislation is to pass on the cost of a "government benefit" to carriers and their policyholders rather than to the taxpayers. That is not a valid regulatory purpose. The legislation does not "regulate" for the purpose of benefiting veterans (whose status is not changed), carriers, or policyholders. Only the government benefits, by taking funds from carriers to pay for governmental programs.

6. "The proposed legislation operates in a classic regulatory fashion * * *."

This is not so. The government's regulatory function is to regulate relations among private parties. In contrast, the purpose of the proposed legislation is to transfer $300,000,000 from insurance carriers to the government to fund an entitlement program.. No amount of rationalization can convert that confiscatory act into a regulatory action.

Sincerely,

Philip S. Neal

Chairman MURKOWSKI. The last witness for this afternoon is Mr. Richard Fogel who will address us as a representative of the Director of the Human Resources Division, General Accounting Office.

We look forward to your testimony. You may introduce your colleagues and proceed.

TESTIMONY OF RICHARD L. FOGEL, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY JAMES LINZ, GROUP DIRECTOR; DAVID BAINE, ASSOCIATE DIRECTOR; AND NANCY FINLEY, OFFICE OF GENERAL COUNSEL

Mr. FOGEL. Thank you, Mr. Chairman.

I would like to introduce my colleagues. On my right is Jim Linz, who is the Group Director in charge of the latest work we did on the potential for third-party reimbursement for non-service-connected care in VA hospitals. Dave Baine is the Associate Director in charge of this area. And Ms. Nancy Finley is from our general counsel's office.

I would like to introduce my statement for the record, highlight a couple of things, and then respond to any questions that the committee may have.

Mr. Fogel. We believe that the estimates in our February 1985 report of cost savings that could accrue from third-party reimbursement are very sound and, indeed, very conservative.

Chairman Murkowski. Very sound and conservative?

Mr. Fogel. Yes, sir; for example, to address the issue of length of stay problems in VA hospitals versus community hospitals, we factored down lengths of stay of veterans discharged from VA hospitals to make them comparable to those of community hospitals.

I think that as one goes through the report—and we would certainly be glad to respond to any additional questions in writing—one would see that those estimates are very conservative.

The other point I would like to make is a legal one. Our general counsel's office, too, has concluded that this proposed legislation is legal. Also, the Justice Department reaffirmed its 1979 position when it commented on our report earlier this year.

Chairman Murkowski. When you say it is legal does that mean to imply that if it is enacted, the health-care agencies will not litigate the issue?

Mr. Fogel. No; that does not mean that we do not think they could——

Chairman Murkowski. Litigate.

Mr. Fogel [continuing]. The insurance industry may challenge it. But we believe it is constitutional.

Chairman Murkowski. Thank you. Go ahead. Proceed.

Mr. Fogel. Two other points. We believe that our estimates of VA's administrative costs again are relatively conservative. We would point out that we were dealing just with inpatient episodes. VA's administrative costs should run about 2 percent of recoveries based on processing of similar claims.

We did ask the Blue Cross/Blue Shield Association, by the way, for information on potential administrative costs to insurers but we were not able to get it from them. However, in looking at insurance companies' administrative costs incurred in the Federal employees health benefit program, we found that the range of administrative costs for insurance companies ran from about 2 percent to 6 percent. In estimating the insurers' potential administrative costs we used the 6 percent rate, which we believe is a fairly conservative rate.

We estimated that for the approximately 112 million individuals with comprehensive hospitalization insurance coverage in the United States, premiums for each of those policyholders would be increased about a dollar a year for each $100 million in VA recoveries.

Now, the range could be anywhere from about $1 up to possibly $3, depending on the extent of VA recoveries.

With that I would like to offer our willingness to respond to any questions.

Chairman Murkowski. Do any of your colleagues care to make statements?

Mr. Baine. No, sir.

Chairman Murkowski. We have heard that the VA would have to make substantial changes in their cost accounting and so forth in order to implement the third-party reimbursement proposal. Could you tell us a little bit about whether this is a major and significant change or whether under the concepts of automation, it is something that is relatively simple?

Mr. Fogel. Well, VA has made progress certainly since 1979 on how they account for their hospital expenditures. And indeed, the fact that they now can use the uniform billing form leads us to conclude that they could effectively implement these procedures.

I might let Mr. Linz give you a little bit of history on that.

Chairman Murkowski. Please go ahead.

Mr. Linz. In 1979, VA was using strict per diem billings. It now can itemize by room and board, physician services and ancillary services. It still could not give an itemized bill that would give a charge for a particular test.

There is an increased use of per diem billing in the private sector as a cost containment measure. And, under a traditional fee-for-service system, a hospital or a physician has an incentive to provide additional services to maximize reimbursement. Under a per diem system you do not have that incentive.

Mr. Fogel. I would also like to point out that under already existing legislation, including the Federal Medical Care Recovery Act, and the Veterans' Health Care, Training, and Small Business Loan Act of 1981, VA now recoups some of its costs from insurance companies in Workmen's Compensation and similar cases. VA does prepare itemized bills when requested and the insurance companies are able to respond to those bills and reimburse the Government.

So we think that VA has come a long way. That does not mean they are perfect, by any means. And we would like to see them continue to improve their financial management capability. But we think they are at a point where they can adequately meet the concerns of the insurance companies for providing good itemized bills.

Chairman Murkowski. The insurers have indicated that the employees or the employers who are located near VA medical centers and those who hire veterans will suffer under the third-party reimbursement proposal because of proximity. Do you agree?

Mr. Fogel. We did not do a specific analysis of this issue. We have read some of the analyses that Blue Cross has done.

I would point out that the premiums would go up for all people.

Chairman Murkowski. How much?

Mr. Fogel. Well, we say they could go up possibly between $1 and——

Chairman Murkowski. A dollar per 100 million.

Mr. Fogel. A dollar per 100 million, which is not a lot. Now, indeed, there could be some variations in how those premium increases would arise based on utilization in certain areas. But we would point out, too, one difference. VA hospitals do not necessarily serve people just for the immediate metropolitan area, as community hospitals do. They draw their population from larger areas. So undoubtedly there would be some increase. But we think it is very insignificant in terms of the total premium that any individual would have to pay, employer or employee.

Chairman Murkowski. You heard the testimony by the health insurers with regard to what they felt was the appropriate role of the Government in providing free VA services and the concern they had over the enrollment of the 17 percent, or whatever it might be, of veterans whose pay is withheld for health coverage, either voluntarily through the employee/employer contribution or just through an employee contribution.

We asked if they had any figures relative to what that equated to as a savings to the pool of those who were the actual exposed group within the coverage area. Do you have any idea what that figure might be or how you could formulate what the savings to the private sector pool at the expense of the taxpayer might be?

Mr. FOGEL. No; I would certainly be glad to have some of our economists address that problem.

Chairman MURKOWSKI. Maybe you could do that and we could ask the economists in the private insurance areas to do theirs and we will open the envelopes at the same time and see how close they come.

Mr. FOGEL. You know, that is a very difficult thing to get a handle on.

Chairman MURKOWSKI. Is it substantive in your opinion?

Mr. FOGEL. Well, I would go back to what Mr. Briggs said. He said we are not talking about a lot of money from the insurance companies' standpoint when we are dealing with this issue. And I would tend to agree with him.

You are talking about the fact that they collected $98 billion in premiums and paid out $88 billion in benefits, I think, in the year that we used to figure the premium rate increases. We are talking here about possible savings to the Government of between, just for inpatient care in the study we did, about $98 million and $284 million. So that is not a significant amount of money to the insurance companies. And indeed, they would pass that on.

I would also point out that as far as employers go, when they pay their part of the premium they deduct that as a business expense.

Chairman MURKOWSKI. That is correct.

Mr. FOGEL. So, indeed, the Government is indirectly, and quite properly so, recognizing that as a cost of doing business.

Chairman MURKOWSKI. Even though there is no direct benefit to that particular employee.

Mr. FOGEL. Yes; except to the extent that his premium may be a little bit lower because if he used the VA hospital it would be reflected in a lower utilization.

Chairman MURKOWSKI. Do you think it would be appropriate to have your agency involved in the VA-CBO staff meeting on the issue of savings?

Mr. FOGEL. We would really like to defer to CBO on that. I think that in terms of the way the support agencies of the Congress work, we really want to try to rely upon CBO to give budget numbers.

We have provided data from the work that we did on the means test to both VA and CBO. Both agencies have that data. I might add that what we did there was run a tape matching VA's files against Internal Revenue Service tapes, to see the number of veterans with certain income levels.

And then using assumptions concerning various means test scenarios, we made several different projections of possible means test impacts. We have provided that information. And I do not believe that we would add anything to that meeting.

However, if the committee requested that we attend, we would certainly be glad to do that.

Chairman **Murkowski**. You were involved in a recent GAO-IRS veterans' sampling, were you not?

Mr. **Fogel**. Yes, we were.

Chairman **Murkowski**. And the fact that you worked cooperatively in that, in your own opinion, does not add anything to the logic of you joining then the CBO and VA in this area?

Mr. **Fogel**. No; I guess my feeling is the numbers that we have are public. Both sides have them. One would have to extrapolate from our information anyway to estimate the impact of the means test VA is now proposing. VA and CBO are as capable as we would be of doing that.

Chairman **Murkowski**. Do you see any way of resolving, or approaching a resolution to, how we can address the continued dilemma of how the VA cost efficiencies relate to the private sector's?

Mr. **Fogel**. Well, we believe that this third party——

Chairman **Murkowski**. Please comment on the allegation that we continually hear that the length of care is extensively longer in the VA as opposed to the private sector when it does not have to be. We get professional opinions on both sides.

Mr. **Fogel**. We support in this proposed legislation dealing with third-party reimbursement, the fact that the insurance industry should be able to use some of the same utilization review and post-audit and preadmissions tests in the VA system as it uses in the private sector. We strongly believe that the VA system should attempt to be as efficient as possible and there is no reason for it to not be as efficient as a private sector health-care system.

And we think that activities like these will give better incentives to VA to do this.

I might point out as an aside that we think one of the problems that the VA system has is that there may be a real lack of incentives for VA hospital administrators to operate their facilities as efficiently as possible. Over the next several years, we intend to look at the incentives that could be given to VA hospital administrators to run their hospitals more efficiently. Under the way the whole budget process works—part of it has to do with the appropriations and allocation processes—there is not now a lot of an incentive for an administrator running a hospital to do things as efficiently as possible.

The administrator gets a budget each year and if they do not spend it——

Chairman **Murkowski**. He loses it.

Mr. **Fogel** [continuing]. He loses it.

And I think that if you really want to look at economic incentives we have to explore in the long term what we can do to make the VA system more responsive to those types of issues.

Chairman **Murkowski**. You feel that what we are undertaking and have discussed here today concerning the means test and third-party reimbursement, is a step in that direction, to instill more efficiencies in the VA system?

Mr. **Fogel**. I think third-party reimbursement would. I do not know that the means test has anything to do with improving the efficiency with which you would run the VA system.

Chairman Murkowski. Do you agree with the potential savings or nonsavings within the means test?

Mr. Fogel. We have not looked at those.

Chairman Murkowski. You have no comment?

Mr. Fogel. No, we do not.

Chairman Murkowski. I assume you have no comments on the equity issue as well?

Mr. Fogel. No.

Chairman Murkowski. Well, quite appropriately.

I have no further questions. We will be undoubtedly submitting questions to you in writing.

Mr. Fogel. I would like to just mention one thing, Mr. Chairman. I did notice in the Blue Cross/Blue Shield Association's testimony that they included as part of the record a letter they wrote to you and provided a copy to the Comptroller General criticizing our February 1985 report on private health insurance.

And we would like to submit for the record, our analysis of the association's comments which, in effect, lead us to believe that we are still very comfortable with the conclusions we have drawn and we do not think that the issues raised by Blue Cross/Blue Shield have much validity.

So I would like to submit that for the record.

Chairman Murkowski. All right.

I want to thank the witnesses representing the General Accounting Office. We appreciate your testimony, Mr. Fogel, particularly in view of the specific recommendations.

[The prepared statement of Richard L. Fogel, Director, Human Resources Division, General Accounting Office; a June 25, 1985, letter to Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, from Richard L. Fogel; and the GAO's response to written questions submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF RICHARD L. FOGEL, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss our February 26, 1985, report, which recommended passage of legislation to authorize VA to recover the costs of care provided to privately insured veterans for non-service-connected medical conditions. In addition, we will discuss our May 3, 1985, report, which provided information that may be useful to the Congress and VA in projecting the potential effects of a means (income) test used to determine whether veterans with non-service-connected disabilities would be eligible for treatment in VA facilities.

VA RECOVERIES FROM PRIVATE HEALTH INSURANCE

Most health insurance policies will not pay for non-emergency care provided to the companies' policyholders at VA medical facilities. Such policies have exclusionary clauses which state that the insurance companies will not pay for care for which the policyholder has no obligation to pay.

VA provided about 1 million episodes of care in fiscal year 1982. About 685,000 of those episodes were provided to veterans for non-service-connected, non-psychiatric conditions. We selected a nationwide sample of veterans associated with those episodes to find out how many had private health insurance coverage. Eighty-three percent of the questionnaires were answered.

Our results showed that about 18 percent of the episodes were provided to veterans who had private health insurance. We estimate that VA could have recovered between $98 million and $284 million from private health insurance for those episodes if the exclusionary clauses had been removed. We believe that our estimates are conservative and that actual VA recoveries would likely be higher.

In addition to developing a reliable estimate of potential VA recoveries, we analyzed concerns raised by the insurance industry and others during this Committee's 1979 hearings on proposed recovery legislation. These concerns included

--the administrative costs VA and the insurance industry would incur,

--the effect VA recoveries would have on health insurance premiums, and

--the legality of recovery legislation.

VA administrative costs

Because VA already has procedures to identify veterans' private health insurance coverage during the admissions process, the increased VA administrative costs would result primarily from preparing and collecting the bills. These costs should be less than two percent of recoveries based on VA's historic costs for processing similar claims.

Insurers' administrative costs

Insurance companies should incur increased administrative costs of less than 6 percent of VA recoveries based on the highest level of administrative costs they incurred under federally administered health insurance programs.

Effect on health insurance premiums

At present, the burden of paying for VA medical care provided to privately insured veterans with non-service-connected medical conditions falls on the taxpayers. If VA is authorized to collect from insurance companies, some of the burden will be initially shifted to those companies. Most likely, however, the insurance companies will in turn shift the burden to policyholders through higher premiums.

In 1982, for the approximately 112 million individuals with comprehensive hospitalization insurance coverage, health insurance benefit payments were almost $88 billion and health insurance premiums were almost $99 billion. We estimate that for every $100 million in VA recoveries, premiums for each of the 112 million policyholders would have increased by about one dollar.

Legality of recovery legislation

During this Committee's 1979 hearings, the Health Insurance Association of America and the Blue Cross and Blue Shield Associations expressed concern about the legality of legislation to prohibit exclusionary clauses. Our review of case law shows that the insurance industry's rights would be adequately protected and that recovery legislation such as that proposed in 1979 would be legal. The Department of Justice also held in 1979 that such legislation would be legal. The Department reaffirmed its position this year in commenting on our report.

Public Law 96-330

The Veterans Administration Health Care Amendments of 1980 were enacted as an alternative to the recovery legislation that was proposed, but not enacted, in 1979. We believe, however, that the 1980 amendments should be viewed as a supplement, rather than an alternative, to such recovery legislation.

These amendments authorized VA to establish specific ability-to-pay criteria and to verify veterans' ability to defray the expenses of non-service-connected care under specified circumstances. VA has not yet published proposed regulations to implement the ability-to-pay provisions.

Whether veterans are covered by private health insurance would be one element in assessing their ability to pay. Although implementing the ability-to-pay provisions would likely reduce the number of veterans with insurance using the VA system, many veterans who are provided care for non-service-connected conditions would be exempt from such provisions. Without recovery legislation, VA would continue to be prevented from recovering costs of care provided to those insured veterans who (1) have service-connected disabilities but receive treatment for non-service-connected conditions, (2) receive a VA pension or are eligible for Medicaid, or (3) are 65 years of age or older.

PROPOSALS FOR A MEANS TEST

The administration's fiscal year 1986 budget proposes a comprehensive reform of eligibility for VA medical care which is to include establishing a means test to determine non-service-connected veterans' eligibility for VA medical care.

Using VA and Internal Revenue Service data, we developed information on the income levels of and cost of care provided to non-service-connected veterans who were discharged from VA hospitals during fiscal year 1981. Our analyses were intended to show how much VA could have recovered from such veterans who had incomes over specified levels in that year.

Because the decision involves a fundamental public policy matter, we have no position as to whether the Congress should enact the administration's proposed means test. Rather, our purpose was to provide information to VA and the Congress so they could assess the potential effects of such a proposal.

There are some limitations to our analyses. We did not fully assess the reliability of the VA and IRS data, such as information on the patients' length of stay, income, and family size. Also, our universe of non-service-connected veterans may contain some who did not meet our selection criteria. We believe, at the most, this number is about 16 percent of our universe. Despite these limitations, our data should be useful in projecting the extent to which veterans with non-service-connected conditions would be eligible for VA care based on the administration's recently proposed means test.

Results of our analyses

Our universe for these analyses included about 146,000 episodes of care provided during fiscal year 1981 to about 101,000 veterans. This universe included veterans who

--had no service-connected disabilities,

--were under age 65,

--were not receiving a VA pension, and

--who filed a 1981 federal tax return.

We developed three possible alternatives to determine how much of their income these veterans could have spent on their health care. We do not intend to suggest them as alternatives to the administration's proposed means test; rather, we developed them to serve as frameworks for analyzing the extent to which veterans could have afforded to pay for all or part of their care.

We applied these alternatives to both our original universe of non-service-connected veterans under age 65 as well as those 65 and over.

Let me give an example of the kind of data our analyses provided. Using the pension-based means test, we found that VA provided about 44,000 episodes of care to veterans under age 65, with no service-connected disabilities, and whose income exceeded twice the pension level. These episodes cost VA about $163 million. Our analysis also showed that these veterans could have paid for about $116 million of that care.

The administration's proposal would subject certain veterans both over and under age 65 who do not have service-connected disabilities to a means test when they applied for VA hospital and nursing home care. We understand that the means test will involve comparing the veteran's family size and income (including assets) to twice the current pension level. We understand that VA has found the information we provided useful in projecting the potential impact of the administration's means test proposal.

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Mr. Chairman, that concludes my prepared statement. We would be pleased to answer questions.

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

June 25, 1985

The Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

On April 25, 1985, the Blue Cross and Blue Shield Association provided comments to you on our February 26, 1985, report Legislation to Authorize VA Recoveries From Private Health Insurance Would Result in Substantial Savings (GAO/HRD-85-24).

The Association believed our analysis was seriously flawed, "raising serious questions about the validity of our conclusions and recommendations."

As discussed in my June 20, 1985, testimony before your Committee, enclosed for inclusion in the hearing record is our detailed analysis of the Association's comments. We believe this analysis provides further evidence of the reasonableness and legality of enacting legislation to authorize Veterans Administration recoveries from private health insurance. We are sending copies of this letter to interested Members of Congress; cognizant committee and subcommittee chairmen; the Administrator of Veterans Affairs; the Director, Office of Management and Budget; and the Blue Cross and Blue Shield Association, all of whom received copies of our February report.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

Enclosures - 4

GAO'S ANALYSIS OF AND RESPONSE TO THE BLUE CROSS AND BLUE SHIELD ASSOCIATION'S COMMENTS

This enclosure presents our analysis of and response to the Blue Cross and Blue Shield Association's comments on our February 26, 1985, report Legislation to Authorize VA Recoveries From Private Health Insurance Would Result in Substantial Savings. (See enc. II.) It also incorporates analyses by the Department of Justice (see enc. III) and the Veterans Administration (VA) General Counsel (see enc. IV) of the Association's legal arguments. We believe our analysis, together with those of VA and the Department of Justice, supports (1) the validity of our recommendation that recovery legislation be enacted and (2) the constitutionality of such legislation.

BLUE CROSS AND BLUE SHIELD ASSOCIATION'S CRITICISM OF OUR STUDY METHODOLOGY

Our report was based on a random questionnaire survey of veterans discharged from VA hospitals in fiscal year 1982 after treatment of non-service-connected disabilities to determine the extent of their health insurance coverage at the time of their VA treatment. We estimated that about 18 percent of the veterans in our questionnaire universe of 345,000 episodes of care had private health insurance and that VA could have recovered from about $98 million to about $284 million from private health insurance if such insurance had not excluded payment for services provided in VA hospitals. Our questionnaire methodology is discussed on pages 60 to 76 of our report.

The Blue Cross and Blue Shield Association said that there were two potentially serious flaws in the methodology we used to estimate expected VA recoveries.

First, according to the Association, we received usable replies from only 1,356 veterans (50 percent) out of an original sample of 2,693. The Association said that about 70 to 80 percent is the lowest response rate generally considered necessary to assure unbiased responses. According to the Association, with response rates below that level, it is considered too likely that respondents differ from nonrespondents and that the survey results are, therefore, not reliable. The Association said that there is some evidence of this problem in our figures that 6 percent of nonrespondents were reported by VA's administrative process to have insurance, while 18 percent of respondents were found by our survey to have insurance.

In developing its estimate of a 50-percent response rate, the Association left out two key steps in our methodology, which we described on pages 72 to 74 of our report. The Association correctly stated that we selected an original sample of 2,693 veterans, but did not note that 890 veterans were dropped from the sample because they were deceased, could not be located, were not treated in a VA hospital, or for miscellaneous other reasons. This left an effective sample size of questionnaires mailed of 1,803. Responses were received from 1,497--a response rate of 83 percent--which exceeded the 70 to 80 percent the Association correctly notes is generally considered necessary to assure unbiased responses.

More importantly, the Association did not note that we adjusted our initial universe from 685,410 to 345,105 based on (1) the percentage of veterans dropped from our sample for the reasons cited above and (2) the percentage of nonresponses to our questionnaires. In other words, our projections were made only to the universe of questionnaire respondents. We did not project recoveries from nonrespondents even though, as the Association notes, many had told VA that they had insurance because, as the Association also notes, nonrespondents may differ from respondents.

In summary, our effective universe was conservative for statistical projection purposes because it underestimated potential VA recoveries.

The second potential flaw cited by the Blue Cross and Blue Shield Association was our use of data on what veterans' insurance covered at the time of the 1982 survey and on general provisions of health insurance at about that time. According to the Association, this early 1980's base misses the enormous surge in deductibles and coinsurance for inpatient care that has occurred since then. The Association said that, in short, insurance will pay for less than it would have at the time we did our fieldwork. It said that the rapid growth of health maintenance organizations and other insurance arrangements that pay for care only if it is obtained from selected providers reinforces this conclusion.

We agree that there has been an increase in deductibles and coinsurance for inpatient care. However, the data presented by the Blue Cross and Blue Shield Association demonstrate that our projections were conservative. We recognized on page 17 of our report that, according to the Health Insurance Association of America, most insurance policies now contain a 20-percent coinsurance provision, but waive further coinsurance once the policyholder's out-of-pocket expenses exceed $2,000. Accordingly, in estimating recoveries, we established a lower limit of recoveries based on the assumption that insurance reimbursement would cover only 80 percent of VA's cost of providing care. This is a conservative estimate because we

--assumed that all policies required cost sharing, whereas the data presented by the Blue Cross and Blue Shield Association show that, in both 1982 and 1984, many policies still covered the costs of inpatient hospital care in full and

--applied no limit to the coinsurance although most policies waive coinsurance and pay 100 percent of billed charges once the policyholder's out of pocket costs exceed $2,000.

In addition, we excluded from our projections veterans who were members of health maintenance organizations.

In summary, our methodology took into account both the uncertainty about nonrespondents' insurance coverage (we excluded nonrespondents from our projections) and the increasing use of deductibles and coinsurance for inpatient care (we assumed for the lower range of our projections that all policies included cost sharing).

COST IMPACT ON PRIVATE SECTOR EMPLOYERS, EMPLOYEES, AND INSURERS

In our report (see pp. 33 to 35) we said that insurance companies would likely pass on the increased benefit payments and administrative costs to policyholders. We said that the $98 million to $284 million in VA recoveries projected in our report should increase health insurance premiums between $0.93 and $2.69 per year for each of the approximately 112 million policyholders with comprehensive hospitalization insurance coverage if the companies pass on the benefit payments and administrative costs to all of their policyholders.

According to the Blue Cross and Blue Shield Association, we minimized the importance of the fact that premium cost increases resulting from mandated third-party payments to VA would be concentrated on particular employers and employee groups. The Association said that the added costs for these groups may be several times as large as the national average.

The burden of costs will, according to the Association, fall disproportionately on geographical areas in which there are

--large proportions of veterans in the population;

--an above-average percentage of veterans who are older and, therefore, use more care; and

--more use of VA care than the national average given the number and age distribution of veterans.

The Association said that specific data are limited, but identified 23 metropolitan areas in which the number of veterans discharged from VA hospitals is more than twice what would be expected based on national averages even after taking into account the number of veterans in the area and their age distribution.

According to the Association, a concentration of new costs would be expected among employers with a high proportion of middle-aged male employees. The Association also said that VA recoveries would have a disproportionate effect on low-wage employers with relatively limited insurance, saying that veterans with low wages and limited insurance are more likely to testify to their inability to pay for their care. The Association acknowledged that the response of employers affected by the proposal in a disproportionate manner is uncertain, but asserted that it is reasonable to expect that covered benefits would be reduced or coverage canceled in some cases.

We recognized in our report (see p. 35) that the effects of the small premium increases that might occur from payment of non-service-connected VA care may vary according to the concentration of veterans covered by individual policies. However, we find unconvincing the Association's arguments that the effects on some employers would be so great that they would cancel insurance coverage for their employees and that policyholders in 23 metropolitan areas would bear the brunt of premium increases.

If, as the Association suggested, VA recoveries would have a disproportionate effect on insurance premiums for certain employers, then an equal, but opposite, effect should be obvious in current premiums. In other words, to the extent that veterans who use VA facilities may be concentrated in certain firms, those employers receive an unfair competitive advantage over other employers because of the additional federal subsidy of their health insurance costs. Accordingly, legislation to authorize VA recoveries from private health insurance would eliminate any current inequities in federal subsidies of employers' health insurance costs rather than create inequities as the Association suggests.

Further, the Association's suggestion that the variations would be so great that employers could be expected to reduce benefits or cancel coverage entirely is unconvincing in the absence of data to show that the disproportionate amount of care provided by VA facilities for such employers has led the Association to offer significantly lower premiums to certain employers.

The data the Blue Cross and Blue Shield Association present to show that the burden of increased premiums would fall disproportionately on certain geographic areas are similarly unconvincing. The "metropolitan statistical area" methodology used by the Association was, according to the VA report from which it was obtained, intended to provide an estimate of "real need" for VA services in the future, not to evaluate current utilization.

In calculating the ratio of actual to expected discharges in the 23 metropolitan areas based only on the number of veterans in the metropolitan area, the Association overlooked a fundamental difference between VA hospitals and community hospitals. In community hospitals, the patient population comes largely from the local community. VA hospitals, however, serve veterans residing both in the metropolitan area in which they are located, the surrounding nonmetropolitan areas, and in many cases, other metropolitan areas that do not have a VA hospital. Accordingly, the ratios should have been calculated using the number of veterans in the VA hospital's service area, not the number of veterans in the metropolitan area.

For example, the effect of this oversight is clearly indicated in the inclusion of both VA hospitals in Mississippi in the Association's list. VA facilities are located in only two of the state's four metropolitan statistical areas. More importantly, 73 percent of the hospital admissions in the state were in nonmetropolitan areas. Accordingly, the Biloxi and Jackson VA hospitals serve veterans living in the nonmetropolitan areas and the two metropolitan areas without VA hospitals.

Similarly, two of the three largest metropolitan areas in North Carolina are without a VA hospital. As a result, veterans living in those cities who desire VA care obtain it from VA hospitals in other metropolitan areas, including Fayetteville and Asheville, two of the areas included in the Association's list.

Accordingly, we do not believe the Association's analysis demonstrates that a disproportionate effect on health insurance premiums would occur in any of the 23 metropolitan areas cited or in any other geographical area.

Finally, the Association's suggestion that the burden of costs will fall disproportionately on geographical areas in which there are large concentrations of elderly veterans ignores the fact that elderly veterans, most of whom have Medicare coverage, are less likely to have private health insurance than their younger counterparts.

In summary, while we agree with the Association that some variation in the effects on premiums will likely occur, we do not agree that the effects will be so great as to cause employers to drop coverage or significantly increase health insurance premiums in certain metropolitan areas.

PRIVATE SECTOR COST CONTAINMENT EFFORTS

In our report (see pp. 51 to 53) we stated that VA's objection to having private insurers review its utilization review programs should not seriously hamper insurance companies' utilization review efforts.

The Blue Cross and Blue Shield Association said that we failed to recognize that the enactment of recovery legislation would transfer major new costs to selected employers who would be unable to apply the same cost containment programs to their employees using VA facilities as they apply to other employees. According to the Association, we incorrectly claimed that mandated payment to VA would not create serious problems for private utilization management. It said that our conclusion was based, in part, on a misunderstanding of the foundation and scope of private health benefit cost management strategies. The Association said that, in particular, we minimized the importance of both provider and subscriber incentives to cooperate with such strategies. According to the Association, our report did not address the inadequacies of VA's utilization review efforts or the lack of independent financial audits of VA costs.

The enactment of recovery legislation would not seriously hamper private sector cost containment efforts; indeed, it would extend some of those efforts to the VA system. The Association's concerns appear to be based, in part, on the misconception that VA recoveries would not be predicated on compliance with the same policy provisions, such as mandatory second surgical opinions, that apply to private sector providers.

Our analysis of the Association's specific concerns about private sector cost containment efforts follows.

Provider and subscriber incentives

According to the Blue Cross and Blue Shield Association, private sector cost containment programs depend heavily on cooperation from providers, cooperation it says may not be forthcoming from VA. The Association said our report minimizes the problems that VA's opposition to having insurance companies review the effectiveness of VA utilization review programs would cause for a wide range of other private sector cost containment programs. These cost containment programs include, according to the Association:

--Mandatory ambulatory surgery - The Association said that it is not clear that VA would honor an employer's mandate that certain procedures be performed on an outpatient basis.

--Mandatory second surgical opinion - The Association said that VA is apparently not willing to accept a requirement that private sector physicians review its physicians' medical decisions.

--Preadmission certification - According to the Association VA is not ready to accept outside direction or oversight of its operations by the private sector.

--Concurrent review.

--Discharge planning.

--Medical practice audits.

The Association said that recovery legislation would also negate an important and effective mechanism to manage utilization--patient cost sharing--and then would require insurers and employers to pay for the excessive use of care that would take place in its absence. The Association said that veterans would be exempt from the incentives that are critical to the success of what are probably the most effective cost containment programs currently in the marketplace: mandatory ambulatory surgery, second surgical opinions for elective surgery, preadmission review of the medical necessity of hospital stays, and preferred provider arrangements.

In our view, the effectiveness of insurance companies' cost containment efforts would not be seriously impaired by enactment of recovery legislation because:

--VA could not collect from health insurance unless it provided care in accordance with policy provisions.

--Patient cost sharing may not be effective in reducing utilization of inpatient services.

--VA's salaried physicians lack the incentive present in the private sector to overprescribe services to maximize income.

--Utilization of VA outpatient services is limited by law.

--VA's resource allocation system is intended to give VA hospitals incentives to reduce hospital stays and costs.

VA recoveries from private health insurance would depend on their compliance with provisions of individual health insurance policies. For example, if the policy will pay for certain procedures only if performed on an outpatient basis, VA would be able to recover for such care only if it provided the care on an outpatient basis. Similarly, VA would be able to recover under policies that require preadmission certification of the need for admission only if it obtained such certification. In short, rather than hindering the cost containment efforts of the private sector, recovery legislation would create incentives for VA to comply with private sector cost containment methods.

We agree that increased consumer cost sharing can constrain the quantity of health care services used. However, an interim report on a long-term study of the effects of cost sharing performed by the Rand Corporation[1] showed that while cost sharing reduced the incidence of hospitalization, increased coinsurance had little impact on the cost of care provided in hospitals. The researchers concluded that, because the out-of-pocket cost threshold had been exceeded for most hospitalized patients, neither the patients nor the physicians had an incentive to seek care in lower cost hospitals or to limit the services received.

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[1] Joseph P. Newhouse, et al., Some Interim Results From a Controlled Trial of Cost Sharing in Health Insurance, Rand Corporation, January 1982, pages v, 12, 16, and 18.

The Association did not discuss one of the primary incentives to overutilization in the private sector that is missing in the VA system--fee-for-service reimbursement of physicians. Consumers generally select providers, primarily physicians, and rely on them to make the key decisions regarding the provision of health care services. For example, in most cases, physicians determine who will go to the hospital, which hospital they will go to, how long they will stay, and what diagnostic and treatment services they will receive. Because consumers are unable to make fully informed choices, physicians are in a position to create their own demand.

In the absence of informed consumers, fee-for-service reimbursement encourages physicians to see patients more often and provide more services or higher cost services in order to maximize reimbursement. Under the VA system, physicians are salaried employees and therefore do not have the same incentive to overprescribe services to increase their income.

VA has another major control on the utilization of outpatient services that the Association did not mention. Veterans are eligible for outpatient treatment of non-service-connected conditions only if such treatment is needed (1) to prepare them for hospital care, (2) to obviate the need for hospitalization, or (3) as a follow-on to hospitalization. This, coupled with the fact that VA operates within defined medical resource constraints, effectively limits the amount of non-service-connected care provided on an outpatient basis.

VA has also implemented a resource allocation system for its hospitals. The system places each patient discharged in 1 of 470 treatment categories, such as hypertension or chest pain. These categories are called diagnosis-related groups, or DRGs. Within limits, each DRG carries a standard reimbursement that is the same regardless of how long the patient actually stays in the hospital.

The system, patterned after Medicare's prospective payment system, allocates resources to VA medical centers based on the case mix of patients provided care. Because facilities with shorter lengths of stay benefit from the case mix allocation, the system is expected to improve medical centers' efficiency.

Utilization reviews

The Blue Cross and Blue Shield Association stated that we overlooked the fact that utilization review in VA hospitals is weak compared to that found in nonfederal hospitals. According to the Association, only half of the VA hospitals have utilization review coordinators, and only about half of those coordinators are full-time. The Association said that, as noted in our report, VA lengths of stay for acute medical and surgical patients are about 70 percent greater than the length of stay for comparable patients in community hospitals. According to the Association, little of VA's utilization review is directed at reducing and eliminating avoidable days of care. The Association said that, in contrast, utilization review in nonfederal hospitals is nearly universal and very much focused on avoidable days of care.

We did not, as the Association maintains, overlook the need to improve utilization review in VA hospitals. As noted on page 16 of our report, we have evaluated, in a separate review, VA lengths of stay to determine whether (1) the longer VA lengths of stay are medically necessary and (2) VA utilization reviews are effective in reducing lengths of stay. We will report on the results of this review shortly.

Furthermore, since private health insurers rely on their own utilization review programs in making payment decisions, the success of their cost containment efforts depends more on the effectiveness of their programs than on the effectiveness of VA's program. We are currently reviewing the effectiveness of private health insurers' utilization review programs under the Federal Employees Health Benefits Program.

As stated on page 53 of our report, we support the Blue Cross and Blue Shield Association's argument that they should have the same rights to perform utilization reviews of VA facilities as they do to review private sector facilities.

Audits of VA recovery rates

According to the Blue Cross and Blue Shield Association, recovery legislation would not give payers the financial safeguards that GAO routinely recognizes as appropriate and necessary when it reviews the operations of government programs. It said that under the legislative proposals, insurers would not be able to audit VA financial records. The Association said that while it doubts the validity of court rulings that the Office of Management and Budget-established charges for VA care cannot be challenged as unreasonable by a liable third party even under the "arbitrary and capricious" standard of the Administrative Procedure Act, it is apparent that VA would have considerable latitude in establishing a reimbursement rate that it deems to be reasonable.

According to the Association, there is evidence to indicate that VA would be generous to the government in establishing that reimbursement rate. The Association said that in 1985 the rate charged the private sector in tort cases is 22 percent higher than the rate the VA charges other government agencies. It said that part of this difference is apparently due to changes in VA's costing practices that private payers would find very difficult to prevent.

Available evidence shows that VA recovery rates, rather than being generous to the government, as the Association suggests, are a bargain for third party payers. The $319 VA charged for one patient-day of acute care in fiscal year 1984 was significantly less than the $443 average expenditure per inpatient day in the private sector. VA per diem rates cover all charges, including physicians' services and ancillary services. By contrast, private sector hospital costs exclude many physicians' and ancillary services costs.

Under the Federal Medical Care Recovery Act, the provisions allowing the government to recover the reasonable value of medical treatment are supplemented by the power of the President to establish appropriate rates for medical care. Presidential orders prescribing regulations under the federal statute are treated as if they are part of the statute itself.[2] The President delegated the authority for determining appropriate medical care recovery rates to the Director, Office of Management and Budget.

As discretionary findings of an executive officer acting within his or her designated sphere of authority, the rates approved by the Office of Management and Budget should not be subject to challenge by the third-party payor nor subject to judicial review.[3] A requirement that the government prove the reasonableness of its rates in each case would make the government's recovery largely dependent on differing conclusions as to the cost of operating federal medical facilities.

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[2] Mitchell v. Flintkote Co., 185 F.2d 1008 (2d Cir.), cert. denied, 341 U.S. 931 (1951); York v. Gaasland Co., 41 Wash 2d 540, 250 P.2d 967 (1952); cf Givens v. Zerbst, 225 U.S. 11, 18 (1921).

[3] United States v. George S. Bush & Co., 310 U.S. 371, 379-80 (1940). See generally Wigmore, Evidence §1355 (3d ed. 1940).

In our opinion, adequate safeguards exist to ensure the reasonableness of the charges. As VA's Assistant Chief Medical Director pointed out in the September 1979 Senate Committee on Veterans' Affairs hearings on S. 759, VA records of these cost accounts and allocations are available for public scrutiny. In addition, we have, on several occasions, reviewed the reasonableness of VA reimbursement rates. For example, we noted on page 22 of our report that in an earlier report (GAO/HRD-84-31) we said that VA's fiscal year 1983 per diem rates were about $42 too low to recover the reasonable value of VA care provided.

Finally, the difference between the rates VA charges the private sector and other federal facilities does not, as the Association maintains, provide evidence that VA would be generous to the government in establishing rates. The difference between VA charges to the private sector and other federal agencies is due to the exclusion of unfunded liabilities, such as a portion of the cost of the federal retirement program, from the rates charged other federal agencies. According to a VA Medical Administration Service official, the unfunded liabilities are excluded from the interagency rates because the same costs apply equally to all agencies and including them would serve no useful purpose. She said that the medical care cost recovery rates charged the private sector are obtained by adding the unfunded liabilities to the rates charged other federal agencies.

In summary, we believe that the combination of cost containment provisions present in the VA system and the applicability of private sector cost containment initiatives to VA care should provide private insurers adequate protections against inappropriate or excessive charges.

CONSTITUTIONALITY OF RECOVERY LEGISLATION

Our report concluded that the insurance industry's rights would be adequately protected under recovery legislation and that such legislation would be legal. (See pp. 36 to 45.)

According to the Blue Cross and Blue Shield Association, the legal analysis supporting our finding that there were no overriding legal problems with implementation of a cost recovery program dealt only with peripheral issues and skirted a central constitutional issue. The Association said that because of the absence of any financial liability on the part of the veterans using a VA facility, it believes that our proposal based on S. 759 would violate the guarantees of the Fifth Amendment of the Constitution against governmental appropriation of private property without just compensation. The purpose of the proposal is, according to the Association, to confiscate corporate funds for governmental use rather than to regulate health insurance products offered in interstate commerce. The Association provided a detailed legal analysis to support its position.

Our report, as stated on page 36, deals with the legal issues raised by the Association and/or the Health Insurance Association of America during the September 1979 hearings on S. 759. In his September 19, 1979, testimony before the Senate Committee on Veterans' Affairs, the Blue Cross and Blue Shield Association's Vice President for Health Care Services said that

> "We believe that [the] principal constitutional issue, however, is not whether Congress has the power to act in this area, but whether the action proposed in S. 759 is in accord with standards of due process, equal protection, and freedom to contract."

We believe the Blue Cross and Blue Shield Association's abandonment of its prior arguments in favor of a new legal argument demonstrates the convincingness of our prior legal analysis. However, we have reviewed the Association's new position and agree with analyses conducted by the Department of Justice (see enc. III) and VA (see enc. IV) that show the argument to be without merit.

VA ADMINISTRATIVE COSTS

In our report (see pp. 23 to 30) we stated that VA's increased administrative costs to recover from private health insurance should be less than 1.8 percent of recoveries based on VA's historic costs for processing similar claims. We estimated that VA would have incurred increased administrative costs of about $1.7 million to recover the $98 million to $284 million from private health insurance projected in our report. We said that because VA already identifies veterans' private health insurance coverage during the admissions process, the increased VA administrative costs would result primarily from preparing and collecting the bills.

The Association said that we underestimated the number of billings that would be involved by (1) excluding outpatient billings and (2) assuming that only one bill would be prepared for each inpatient episode. According to the Association, our estimates of VA administrative costs should be multiplied about twenty-fold because the VA system provides 20 times as many outpatient visits as inpatient episodes of care. In addition, the

Association said that inpatient episodes of care would frequently involve billings to different insurance companies for physicians' services, hospitalization coverage, and major medical protection. The Association said that it believes VA's administrative cost estimate of $50 million a year is more realistic than ours.

According to the Association, we understated greatly the administrative costs that VA would incur to implement a recovery program by underestimating the number of billings that would be prepared and assuming that VA would not incur costs to identify insurance coverage.

The Association also criticized our report for assuming that VA is already identifying veterans who have insurance coverage. According to the Association, identifying insurance coverage almost certainly receives minimal attention since it now rarely serves any purpose. The Association said that its view is confirmed by our finding that 6 percent of a group of patients were identified as insured by the VA administrative process. According to the Association, this figure is only a fraction of what other surveys have estimated and probably is evidence that the coverage determination stipulated in the manuals is not taken seriously.

As stated on page 56 of our report, we recognize that the actual number of billings, and thus VA administrative costs, will likely be higher than the 63,371 billings and $1.7 million we noted because we could, in accordance with sound statistical principles, project only to the universe from which we sampled. We agree with the Association that, to the extent that multiple billings must be prepared for a single inpatient episode, administrative costs will increase. We do not, however, agree with the Association that VA's 3.8 million billings and $50 million a year in VA administrative costs is more realistic. Unlike VA, we did not double-count veterans with multiple coverage. Furthermore, unlike VA, we did not include in our estimates veterans who (1) were health maintenance organization members, (2) did not have comprehensive hospitalization coverage, (3) did not have insurance at the time they received care from VA, or (4) were provided services not covered by their insurance. A more detailed discussion of VA's administrative cost estimate is contained on page 57 of our report.

It is important to note that while an increase in the number of VA billings would increase VA administrative costs, it would also result in a corresponding increase in VA recoveries.

As stated on page 56 of our report, our projections, as well as VA's, show that a cost recovery program would be cost effective. Accordingly, concern over the specific amount of VA administrative costs should not be a deterrent to the enactment of recovery legislation.

The evidence the Association provides to suggest that VA does not currently identify insurance coverage is not convincing. It cites data showing that 6 percent of a sample of veterans with non-service-connected conditions who were deceased, could not be located, or did not respond to our questionnaire had indicated to VA that they had private health insurance and suggests that it is only a fraction of what other surveys have estimated. We are not aware of any survey that estimates the extent of insurance coverage of questionnaire nonrespondents. In fact, the Association recognized the inappropriateness of such attempts elsewhere in its comments. Accordingly, there is no basis for assuming that more than 6 percent of the nonrespondents had insurance coverage.

In summary, we continue to believe that our estimate of VA administrative costs is reasonable.

Blue Cross
and
Blue Shield
Association

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Washington, D.C. 20006
202/783-6222

April 25, 1985

The Honorable Frank H. Murkowski
U.S. Senate
317 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Murkowski:

As you requested, enclosed are our comments on the recent General Accounting Office report "Legislation to Authorize VA Recoveries From Private Health Insurance Would Result in Substantial Savings" (GAO/HRD-85-24). Staff of the Blue Cross and Blue Shield Association were interviewed by the GAO during its investigations. We were not, however, provided an opportunity to review and comment on the report prior to its issuance.

We believe that the GAO analysis is seriously flawed. In particular, the following problems exist:

1. In assuming that there would be minimal impact on health insurance premiums, GAO omitted any analysis of the unevenness of the cost impact of the proposal on employers and employees.
2. GAO's analysis did not take into account the concern that employers and insurers would not be able to apply the wide variety of cost containment mechanisms they now use by employers and insurers, and its conclusions about private sector utilization review (UR) programs result from a misunderstanding of UR as it is practiced by many private organizations today.
3. GAO's legal analysis does not fully address the fundamental constitutional issue. In the opinion of our outside counsel, Miller & Chevalier, Chartered, the proposal is unconstitutional.
4. GAO underestimated the administrative costs involved.

We believe these problems raise serious questions about the validity of the GAO's conclusions and recommendations. Our detailed comments on these points, plus our specific concerns about the adequacy of the GAO's study methodology, are enclosed.

Also enclosed is the detailed legal analysis conducted by Miller and Chevalier. If you have any questions, please contact me at 783-6222.

Sincerely yours,

Mary Nell Lehnhard
Vice President

cc: The Honorable Charles A. Bowsher
Comptroller General

Enclosures

Detailed Comments of the Blue Cross and Blue Shield Association on General Accounting Office Report, "Legislation to Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings" (GAO/HRD-85-24).

April, 1985

BACKGROUND

By law, the United States provides free medical care in VA hospitals to certain veterans. Some veterans are also covered by private health benefit plans provided through their employers or the employers of their spouses.

Because the fundamental purpose of insurance is to protect individuals against financial loss, there are no benefits payable under private insurance when veterans receive care free of charge at VA facilities. Insurance contracts typically have "exclusionary clauses" which restate this rule of nonpayment for free care, however, the concept is fundamental to the principle of insurance and not dependent on such clauses. Insurance contracts may also specifically exclude payment for care provided by government hospitals and that also has grown out of the fact that government hospitals generally do not charge for care provided to patients meeting eligibility criteria.

The effect of this principle of nonpayment for free care is reflected in the cost of insured and self-funded employee health benefit plans. Because the costs reflect only expenses actually incurred by the group, the costs are lower to the extent that employees use VA facilities or any other facilities that do not charge for their services.

The GAO is proposing that Congress require insurers and self-funded plans to pay for care the VA provides free of charge. The legislation would attempt to accomplish this by voiding the contract exclusions in group insurance contracts and self-funded plans that exclude benefits for free care insofar as they apply to veterans' hospitals. The purpose of this legislation is to transfer, according to the GAO's estimates, about $100 million or more from private insurance to the government to reduce the government's expenditures for care of veterans in VA hospitals.

A number of parties have raised serious problems with such legislation. The General Accounting Office (GAO) examined these in a report entitled "Legislation to Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings" (GAO/HRD-85-24).

The following are the comments of the Blue Cross and Blue Shield Association on the GAO analysis:

I. Cost Impact on Private Sector Employers, Employees, and Insurers

In assuming that there would be minimal effect on private health insurance premiums, the GAO minimized the importance of the fact that premium cost increases resulting from mandated third-party payments to the VA would be concentrated on particular employers and employee groups. For these groups, the added costs may be several times as large as the national average.

Specific data are limited, but two types of concentration should be expected: geographic concentration and concentration on certain types of groups.

Geographically, the burden of costs will fall disproportionately on areas in which there are (is):

1) large proportions of veterans in the population;

2) an above average percentage of veterans who are older—and, therefore, use more care; and

3) more use of VA care than the national average, given the number and age distribution of veterans. (This typically occurs where the number of VA hospital beds exceeds the national average.)

Quantitative information is available on this third point. It shows twenty-three metropolitan areas in which the number of veterans discharged from VA hospitals is more than twice what would be expected based on national averages even after taking account of the number of veterans in the area and their age distribution. These high use areas are:

Metropolitan Area	Ratio of Actual to Expected Discharges
Alexandria, LA	3.5
Amarillo, TX	2.2
Asheville, NC	3.0
Augusta, GA	2.9
Biloxi-Gulfport, MS	2.5
Boston, MA	2.6
Fayetteville, NC	2.2
Fayetteville, AR	3.0
Gainesville, FL	2.4
Jackson, MS	2.6
Killeen-Temple, TX	3.4
Lexington, KY	2.3
Lincoln, NE	2.4
Little Rock, AR	2.6
Montgomery, AL	2.5
Pine Bluff, AR	2.0
Reno, NV	2.1
Roanoke, VA	2.5
Shreveport, LA	2.2
Sioux Falls, SD	2.4
Topeka, KA	3.2
Tuscaloosa, AL	2.1
Waco, TX	3.7

Source: Calculated based on VA data and methodologies used in the 1984 VA report, Caring for the Older Veteran. See "Metropolitan Statistical Area Based Method" p. I-3 in Appendix I.

With regard to the effect on particular types of groups, a concentration of new costs would be expected among employers with high proportions of veterans (e.g. those with high proportion of middle-aged male employees). The proposal would also have a disproportionate effect on low-wage employers with relatively limited insurance. In order to receive free care in a VA facility, most insured veterans have to testify to their inability to pay for care; inability to pay is more likely among veterans with low wages and limited insurance (i.e. insurance that requires high out-of-pocket expenditures.) The response of employers affected by the proposal in a disproportionate manner is uncertain; it is reasonable to expect, however, that a reduction in covered benefits or cancellation of coverage entirely would occur in some cases.

II. Private Sector Cost Containment Efforts

The GAO's report fails to recognize that the proposal would transfer major new costs to selected employers who would be unable to apply the same cost containment programs to their employees using VA facilities as they apply to other employees. The GAO report claims incorrectly that mandated payment to the VA would not create serious problems for private utilization management. Their conclusion is based, in part, on a misunderstanding of the foundation and scope of private health benefit cost management strategies. In particular, the GAO minimized the importance of both subscriber and provider incentives to cooperate with these strategies. Also, the GAO report does not address the lack of independent financial audit of VA costs or the inadequacies of the VA's own utilization review efforts.

A. Subscriber Incentives

A wide range of activities are necessary to support the implementation of effective utilization management strategies. Appropriate financial incentives for subscribers, as well as education, are critical to these activities. One incentive for the subscriber is the risk of bearing a greater out-of-pocket cost if he or she does not cooperate with the payer's utilization management program. This greater cost-sharing can come through the reduction or denial of benefits to the subscriber. Selectively applied, patient cost-sharing incentives support what are probably the most effective cost containment programs currently in the marketplace: mandatory ambulatory surgery, second surgical opinions for elective surgery, pre-admission review of the medical necessity of hospital stays, and preferred provider arrangements.

The legislative proposal recommended by the GAO does not allow for patient cost-sharing for insured veterans who use VA health facilities. As a result, these veterans would be exempt from the incentives that are critical to the success of the specific cost containment programs previously mentioned. In addition, to the extent that the overall patient cost-sharing features of the private health benefits plan deter the excessive use of services, this advantage would be lost for the veteran with private coverage. For some employers with high proportions of veterans in areas with VA facilities, the exemption of certain employees from cost-containment provisions could be a real cost and employee morale problem.

In summary, the legislation recommended by the GAO would negate an important and effective mechanism to manage utilization — and then would require insurers and employers to pay for the excessive use of care that would take place in its absence.

B. Provider Incentives

In addition to subscriber incentives, private sector cost containment programs also depend heavily on cooperation from providers. While the GAO report acknowledges that the "VA remains opposed to having insurance companies review the effectiveness of VA utilization review programs" (p. 51), it minimizes the problems that this fundamental lack of cooperation would cause for a wide range of other private sector cost containment programs. These include:

- Mandatory ambulatory surgery — It is not clear that the VA would honor an employer's mandate that certain procedures be performed on an outpatient basis. Indeed, the VA has placed little emphasis on ambulatory surgery.
- Mandatory second surgical opinion — The VA is apparently not willing to accept a requirement that private sector physicians review its physicians' medical decisions.
- Pre-admission certification — Again, the GAO report suggests that the VA is not ready to accept outside direction or oversight of its operations by the private sector.
- Concurrent review.
- Discharge planning.
- Medical practices audits.

The Minnesota Blue Cross and Blue Shield's AWARE program is one example of the effective use by the private sector of both provider and subscriber cost containment incentives. It depends on contracts with hospitals under which they accept length of stay screens and participate in special utilization review programs. The AWARE hospital contract is backed up by physician contracts that require set terms for specialty and hospital referrals, utilization review, and other cost-containing practices. In addition, subscribers have financial incentives to use AWARE providers and to otherwise cooperate with cost containment programs. Other Plans have similar programs that include both subscriber and provider incentives to avoid hospitalization and lengthy hospital stays.

The legislative proposal recommended by the GAO would tend to undermine the cost-containing incentives of programs like AWARE not only as they affect subscribers but also as they affect providers. Providers operating in a competitive environment have reasons to demonstrate efficiency to private payers that VA hospitals will not have. In fact, as unilateral and uninhibited price setters, the VA would have every reason to inflate prices, yet the proposed legislation provides inadequate protections for the private sector to counter this.

C. Financial Audits

Under the legislative proposal, insurers would not be able to audit VA financial records. GAO notes that current reimbursement legislation authorizes recovery of the "reasonable value" of care provided and cites court rulings that the OMB-established charges for VA care cannot be challenged as unreasonable by a liable third party.

While we doubt the validity of those cases which hold that the agency's decision cannot be reviewed even under the "arbitrary and capricious" standard of the Administrative Procedure Act, it is apparent that the Veterans' Administration would have considerable latitude in establishing a reimbursement rate which it deems to be reasonable. There is evidence to indicate that the VA would be generous to the government in establishing that reimbursement rate. For example, we understand that in 1985, the rate charged the private sector in tort cases is 22% higher than the rate the VA charges other government agencies. Part of this difference apparently is due to changes in VA's costing practices. Private payers would find it very difficult to prevent these practices. The legislation GAO endorses, therefore, would not provide payers with the financial safeguards that GAO routinely recognizes as appropriate and necessary when it reviews the operations of government programs.

D. VA's Utilization Review Efforts

Another serious problem is that the GAO report overlooks the fact that utilization review (UR) in VA hospitals is weak compared to that found in non-Federal hospitals, the setting in which private insurers do pay bills. Only half of VA hospitals have UR coordinators, and only about half of those coordinators are full-time. As the GAO report notes, VA length of stay for acute medical and surgical patients is about 70% greater than the length of stay for comparable patients in community hospitals. We understand that little of the VA's UR is directed at reducing and eliminating avoidable days of care. The VA's attitude toward extra days of care is illustrated by the following statement included in an official VA document: "An additional few days of hospitalization may be considered preferable to having patients who reside some distance from a VA medical center return soon after for follow-up outpatient care." (Veterans Administration, Fiscal Year 1986 Budget Estimates Vol. II: Medical Appropriations and Funds, pp. 5-5 and 5-6.)

In contrast, in non-Federal hospitals, UR is nearly universal and very much focused on avoidable days of care. In short, VA hospitals appear to lack the utilization control mechanisms which are an important part of the environment in which insurance reimbursement normally operates.

III. Legal Problems

We believe that, in finding that there are no overriding legal problems with implementation of a cost recovery program, the GAO dealt only with peripheral issues and skirted a central constitutional issue. The purpose of insurance is to protect - indemnify - a subscriber against a financial loss. Thus under the terms of insurance contracts, there are no benefits payable for care for which the insured has no obligation to pay.

Because of the absence of any financial liability on the part of veterans using a VA facility, we believe that the GAO proposal, which is based on S. 759, would violate the guarantees of the Fifth Amendment of the Constitution against governmental appropriation of private property without just compensation. The purpose of the proposal is to confiscate corporate funds for governmental use rather than to regulate health insurance products offered in interstate commerce.

Our analysis follows:

The Fifth Amendment of the Constitution of the United States requires that no "private property be taken for public use, without just compensation." The purpose of the Amendment is to "bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." Armstrong v. United States, 364 U.S. 40, 49 (1960). The clause was designed to prevent the "arbitrary use of governmental power" to exact "forced contributions" to the government. Webb's Fabulous Pharmacies Inc. v. Beckwith, 449 U.S. 155, 164 (1980).

A. The Government Cannot Take Property Without Compensation In the Conduct of Its Own Enterprises.

The Supreme Court has recognized that the principles of justice and fairness in the Fifth Amendment require that government must pay for intrusions on property rights when the government is appropriating property for its own use to enable it to operate one of its governmental functions, or one of its "enterprises." [1] The government acts in an enterprise capacity when it does such things as operate a post office, build roads and dams or maintain an army. Sax, Takings and the Police Power, 74 Yale L.J. 36, 62 (1964); Penn Central Transp. Co. v. New York City, 438 U.S. 104, 135 (1978).

As the Supreme Court has recently pointed out, a classic example of this is the case of United States v. Causby. Penn Central, 438 U.S. at 135. In Causby, low-flying airplanes landing at a military airport destroyed the utility of a neighboring farm, and the government was required to pay for the property. United States v. Causby, 328 U.S. 256 (1946). The Court recognized that the government had appropriated the property for "entrepreneurial operation" of a military airfield. Penn Central, 438 U.S. at 135. See also Armstrong v. United States, 364 U.S. 40, 48-49 (1960) (Navy must pay materialmen's liens on supplies for boats since it was the "direct, positive beneficiary of the property" acquired); Webb's Fabulous Pharmacies, Inc. v. Beckwith, 449 U.S. 155, 164 (1980) (appropriation by clerk of county court of interest on funds held by the court unconstitutional as "forced contribution to general government revenues").

B. The Government is Acting in Its Enterprise Capacity When It Forces Insurers to Pay for Free Care in VA Hospitals.

GAO's proposal is the precise kind of action which the Fifth Amendment was intended to bar.

The proposal is not a valid exercise of the police power, and it does not purport to be. GAO does not purport to be recommending the use of Congress' authority under the Interstate Commerce Clause to protect beneficiaries of insurance contracts. It is not claiming that state regulation of insurers under the McCarran-Ferguson Act (15 U.S.C. 1012) is no longer appropriate. GAO's proposal is not even necessary to protect the veterans who are insured under their employers' group health policies as their status will not change (except to the extent they might pay higher insurance premiums); the veterans do not pay for the care under existing law, and they will not pay for the care under the proposed legislation. Thus, any attempt to justify this proposal as a valid regulation of insurers under the Interstate Commerce Clause must fail.[2]

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[1] This principle is to be distinguished from the general right of the government to intrude on private property, and affect the property's value adversely, without compensation, in the lawful exercise of its police power. For example, the government can close down a plant, because its operation is hazardous to the public health, without compensating the owner. Mugler v. Kansas, 123 U.S. 623 (1887). But, the courts have sometimes found that regulation even under the police power goes too far, and the interests of fairness require compensation. Goldblatt v. Hempstead, 369 U.S. 590, 594 (citing Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 415 (1922)).

Nor can GAO justify this action as a mere exercise of the VA's legal rights against insurers similar to VA's rights under the Federal Medical Recovery Act. 42 U.S.C. 2651-2653. That Act gives the government a right to sue tort feasors (and their insurers) who injure military employees to recover the medical costs the government incurs. The statute has no effect on the contractual rights of insurers and their insureds.

This proposal is entirely different. First, neither the insurers nor any of their subscribers have caused an injury to any veteran which could give the VA a legal right to sue for recovery. Second, unlike the Recovery Act, this proposal would vitiate basic provisions of contracts between an insurer and its insureds.

The proposal is a stark example of the arbitrary use of government power to cause a direct transfer of millions of dollars from health insurers and employers to the VA to provide the government with resources to meet the obligations the government has undertaken to care for certain veterans. As such, this attempt to exact a "forced contribution to general government revenues" (*Webb's*, 449 U.S. at 163) is indistinguishable from other similar actions by the government in its enterprise capacity which the Supreme Court has found to be unconstitutional.

The fact that the Fifth Amendment was probably adopted in response to the Revolutionary War abuses by the government in obtaining supplies for the army "by impressment," only serves to reinforce this conclusion. Sax, *supra* at 58. And though the circumstances change, the dangers of arbitrary government do not. Justice Rehnquist recently warned against easy solutions sought by governments with financial problems. *Penn Central*, 438 U.S. at 153 (Rehnquist, J., dissenting). The danger is "some may believe that certain costs will be more easily borne by corporations" than the taxpayers. But the financial problems should not allow us to achieve " a shorter cut than the constitutional way."

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[2] That Congress perceives that it cannot directly regulate insurers in this circumstance is clear from its previous actions in shifting Medicare and veterans' medical costs from the federal government to private insurers. Once, when it limited the entitlement of veterans in certain circumstances to free care *only* when the veteran could show he did not have the means to pay for medical care, it proceeded completely properly. Twice — when it decided to shift the medical costs of the working aged and individuals with kidney disease from Medicare to the private sector — it found regulatory vehicles which are arguably subterfuges for unconstitutional takings. But, in no case did Congress directly regulate insurers.

IV. VA Administrative Costs

We believe that GAO understated greatly the administrative costs that the VA would incur to implement the proposal.

First, GAO's estimate for administrative costs are based on billing for inpatient care only. However, the VA system provides approximately 20 times as many outpatient visits as inpatient episodes of care. If insurance coverage for outpatient care is about as widespread as coverage for inpatient care, then GAO estimates of VA administrative costs should be multiplied about twentyfold. (Because much VA outpatient care is pre- or post-hospitalization care, insurance coverage of it will, in fact, be relatively extensive.) As stated in appendix VIII to the GAO report, the VA estimates its administrative costs at approximately $50 million a year; GAO's estimate is approximately $1.7 million. Most of this difference is due to the number of bills involved. We believe the VA's estimate is the more realistic.

Second, GAO assumes the VA is already carrying out one of the three tasks involved in billing—namely, ascertaining which veterans have insurance coverage. (See pp.23-25 of the GAO report.) In reality, this function may be stipulated in the VA procedure manuals, but almost certainly receives minimal attention since it now rarely serves any purpose. This view is confirmed by the GAO report figure that 6% of a group of patients were identified as insured by the VA administrative process. This figure is only a fraction of what other surveys have estimated, and probably is evidence that the coverage determination stipulated in the manuals is not taken seriously. Thus, contrary to GAO, the VA would incur additional administrative costs simply to find out if veterans have insurance.

Third, GAO assumes that each inpatient episode of care will involve a single bill. In reality, coverage for physicians' services often involves a different insurer than does coverage for hospital care, and it is not uncommon for the major medical protection to be underwritten by a third carrier. These additional billings would increase administrative costs.

The understatement of VA administrative costs is also suggested by the experience of the Massachusetts state veterans nursing homes which GAO examines in its report. These homes cite administrative costs for billings of 12-13% of collections.

V. Methodological Problems

There are two potentially serious flaws in the methodology used by the GAO to estimate expected VA recoveries.

First, of an original sample of 2,693 veterans, GAO received usable replies from only 1,356—or 50%. Approximately 70-80% is the lowest response rate generally considered necessary to assure unbiased responses. Below that level, it is considered too likely that respondents differ from non-respondents and that the survey results are, therefore, not reliable. There is some evidence of this problem in GAO's figures that 6% of non-respondents were reported by the VA's administrative process to have insurance, while 18% of respondents were found by the GAO survey to have insurance.

Second, the GAO estimates are based on what veterans' insurance covered at the time of the 1982 survey and on general provisions of health insurance at about that date--or even a year or two earlier. (See pp. 17-18 of the report.) This early 1980's base misses the enormous surge in deductibles and coinsurance for inpatient care that has occurred since then. For example, a Hewitt Associates' survey showed the following very large differences between employee benefit plans in 1982 and in 1984:

Plans with	1982	1984
Deductible for inpatient hospital care	30%	63%
Coinsurance for inpatient hospital care	33%	58%
Deductible for inpatient surgery	34%	59%
Coinsurance for inpatient surgery	58%	74%

In short, insurance will pay for less than it would have at the time GAO did its field work. The very rapid growth of HMOs and of other insurance arrangements which only pay for care if it is obtained from selected providers reinforces this conclusion.

SUMMARY AND CONCLUSION

Based on the foregoing analysis, we believe that the GAO report is seriously flawed. In particular, the following problems exist:

1. In assuming that there would be minimal impact on health insurance premiums, GAO omitted any analysis of the unevenness of the cost impact of the proposal on employees.

2. GAO's analysis did not take into account the concern that employers and insurers would not be able to apply the wide variety of cost containment mechanisms now used, and its conclusions about private sector utilization review (UR) programs result from a misunderstanding of UR as it is practiced by many private organizations today.

3. GAO's legal analysis does not fully address the fundamental constitutional issue. In the opinion of our outside counsel, Miller & Chevalier, Chartered, the proposal is unconstitutional.

4. GAO underestimated the administrative costs involved.

We believe these problems raise serious questions about the validity of the GAO's conclusions and recommendations.

Office of Legislative and Intergovernmental Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

April 26, 1985

Hon. Frank H. Murkowski,
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D. C. 20510

Dear Senator Murkowski:

This letter responds to your request for this Department's views concerning the constitutionality of proposed legislation concerning third party reimbursement from private health insurers for care provided by the Veterans Administration in connection with non-service connected disabilities. As noted in the letter dated January 28, 1985 from Anthony C. Liotta to William J. Anderson, reproduced as Appendix VII to the Comptroller General's Report to Congress dated February 26, 1985 (the "Comptroller General's Report") concerning this legislation, the Department of Justice perceives no constitutional barrier to the proposed legislation, and generally affirms the legal analysis included in Chapter 4 of the Comptroller General's Report. Moreover, this Department on two prior occasions opined that Congress constitutionally may legislate to prohibit clauses in private health insurance policies excluding coverage for care provided at Veterans Administration hospitals for non-service connected disabilities. See letter dated April 14, 1979 to Hon. Alan Cranston, Chairman, Senate Committee on Veterans' Affairs, from Patricia M. Wald, Assistant Attorney General, Office of Legislative Affairs; letter dated June 11, 1973 to Paul H. O'Neill, Associate Director for Human and Community Affairs, Office of Management and Budget, from Robert G. Dixon, Jr., Assistant Attorney General, Office of Legal Counsel.

Having carefully reviewed the memorandum of law prepared by Miller & Chevalier for Blue Cross and Blue Shield Association enclosed with your letter, we strongly adhere to our view that the proposed legislation is constitutional. In particular, we disagree with Miller & Chevalier's conclusion that the proposed legislation would violate the guarantees of the Fifth Amendment of the Constitution against governmental appropriations of private property without just compensation. The Supreme Court has adopted a pragmatic, case-by-case approach to determining whether a particular governmental action constitutes a "taking" for purposes of the Fifth Amendment. It has described the appropriate analysis as follows:

> In engaging in these essentially ad hoc, factual inquiries, the Court's decisions have identified several factors that have particular significance. The economic impact of the regulation on the claimant and, particularly, the extent to which the regulation has interfered with distinct investment-backed expectations are, of course, relevant considerations. So, too, is the character of the governmental action. A "taking" may more readily be found when the interference with property can be characterized as a physical invasion by government than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good.

Penn Central Transportation Co. v. New York City, 438 U.S. 104, 124 (1978)(citations omitted). See also, e.g., Lorretto v. Teleprompter Manhattan CATV Corp., 458 U.S. 419 (1982) (generally endorsing balancing approach but adopting a per se rule for permanent physical occupations); Pruneyard Shopping Center v. Robins, 447 U.S. 74, 83 (1980); Kaiser Aetna v. United States, 444 U.S. 164, 174 (1979).

Applying this analysis, we think it clear that the legislation at issue here would not constitute a "taking." The legislation's economic impact on private insurers would be de minimus, and would not in any meaningful sense interfere with private insurers' "distinct investment-backed expectations." In this regard, it is significant that the proposed legislation is prospective only in that it prohibits exclusionary clauses only in insurance policies entered into, renewed or modified after its effective date. The proposed legislation does not prohibit insurance carriers from adjusting their premiums to take account of their new liability for care provided at Veterans Administration facilities. Based on the Comptroller General's analysis, there is no reason to believe that any such premium increases would be substantial, or that they would affect the demand for health insurance. See Comptroller General's Report at pp. 33-35. In short, there is no reason to believe that the ultimate economic impact of the proposed legislation on private insurers will be more than minimal.

Moreover, the proposed legislation does not involve any physical invasion by the government, and is, in our view, well within the government's power to regulate. Under current law, the taxpayers bear the cost of providing certain health care to veterans for non-service connected disabilities. As to veterans with health insurance, this government subsidy ultimately benefits either the health insurance carrier (if premiums are not lowered to take account of the free care available to veterans) or all policyholders (if premiums are lowered). Congress may reasonably determine that it is in the public interest to spread part of the cost of providing this health care among all persons (or all veterans) with health insurance in order to preclude either a windfall to the health insurance companies or a government financial benefit to nonveteran policyholders. To accomplish this objective, Congress may exercise its clear power to regulate insurance, see United States v. South-Eastern Underwriters Association, et. al, 322 U.S. 533 (1944), to require that all health insurance policies cover care provided at Veterans Administration facilities for non-service connected disabilities. In effect, Congress would be determining that all health insurance covering veterans must include coverage for certain care provided at Veterans Administration facilities, i.e., that the Government will not pay the cost of providing certain health care for non-service connected disabilities to the extent that a veteran is covered by health insurance for the types of medical services at issue. We see no reason why Congress may not so regulate health insurance policies to ensure that a government benefit is not used to subsidize health insurance carriers or non-veteran policyholders.

We disagree with Miller & Chevalier's assertion that this proposed legislation is analogous to the Florida provision at issue in Webb's Fabulous Pharmacies, Inc. v. Beckwith, 449 U.S. 155 (1980), which authorized the clerk of a county court not only to charge a reasonable fee for services rendered, but also to appropriate for the government all interest earned on interpleaded funds deposited with him. As the Supreme Court noted, the Florida provision required a "forced contribution to general government revenues" for which the county could not offer any police power justification. 449 U.S. at 164. In contrast, the proposed legislation at issue here serves the legitimate legislative aim of providing health care to veterans in an economically efficient manner without imposing any unfair or unreasonable economic burden on insurance carriers. Far from "taking" property belonging to private parties, the proposed legislation simply determines how certain government subsidies will be allocated in the future. The proposed legislation operates in classic regulatory fashion in that it governs only future conduct, and allows private insurers (and all others affected) to adjust their behavior in light of the regulation.

For these reasons, nothing in the Miller & Chevalier memorandum of law causes us to change our prior opinion that the proposed legislation is constitutional.

Sincerely,

Phillip D. Brady
Acting Assistant Attorney General
Office of Legislative and
Intergovernmental Affairs

Veterans
Administration

APR 24 1985

In Reply Refer To:
021:REB

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Pursuant to your request of April 15, 1985, enclosed please find a white paper on the constitutionality of proposed legislation to void exclusionary clauses in health insurance policies.

Please let me know if you have any further questions on this subject.

Sincerely yours,

Donald L Ivers

DONALD L. IVERS
General Counsel

Enclosure

WHITE PAPER

CONSTITUTIONALITY
OF
PROPOSED LEGISLATION VOIDING EXCLUSIONARY CLAUSES IN HEALTH INSURANCE POLICIES

(1985)

CONSTITUTIONALITY OF PROPOSED LEGISLATION VOIDING EXCLUSIONARY CLAUSES IN HEALTH INSURANCE POLICIES

The Veterans Administration has proposed legislation to amend section 629 of title 38, United States Code, to authorize the United States to recover the cost of hospital, nursing home, or outpatient medical care furnished or paid for by the VA to veterans with no service-connected disabilities to the extent of any coverage under a private health insurance policy or similar contract or plan.

Section 629 is the current authority for the VA to collect its costs under no-fault, workers' compensation, and crime-victims' statutes. The proposed legislation would add private health insurance policies to these sources of recovery and would affect policies entered into, renewed, or modified after the first day of the fourth month following the month of enactment.

Commercial insurance companies were reimbursing the VA for these costs prior to the adverse decision in United States v. St. Paul Mercury Indem. Co., 238 F.2d 594 (8th Cir. 1956). The court held in that case that, since the veteran was entitled to care at the VA without cost, the requirement under the insurance policy to pay only for expenses actually incurred obviated the company's payment obligation. A more recent attempt at reimbursement met a similar fate. See United States v. Metropolitan Life Ins. Co., 683 F.2d 1250 (9th Cir. 1982). These cases demonstrate the need for legislation to overcome the clauses in policies that prevent VA recoveries.

Due Process of Law

As early as 1970, the question of the constitutionality of such legislation was entertained. In a February 6, 1970, letter to the Director, Bureau of the Budget, the Deputy Attorney General of the United States expressed some reservation as to whether the obstacles to reimbursement could be overcome by regulation, but left no doubt that a legislatively established program would be constitutional, provided it was drafted so as to avoid affecting existing contracts:

> However, we believe that Congress could accomplish this result by statute. Of course, any attempt to alter existing contractual obligations would raise a serious problem of deprivation of due process of law. See Lynch v. United States, 292 U.S. 571 (1934); Pennsylvania Coal Co. v. Mahon, 260 U.S. 393 (1922). But Congress could provide, in effect, that contracts entered into subsequent to the effective date of the statute may not exclude from coverage hospital care furnished by the Veterans Administration for non-service-connected disabilities. Clearly, such legislation would not raise any constitutional problems on due process grounds. As to the constitutional basis for such a regulation of the terms of private contracts, we believe that as part of its authority to provide veterans' benefits Congress may enact necessary and proper legislation to see that such benefits accrue only to the intended recipients and thus to protect the public treasury from windfall gains by insurance carriers. See United States v. Standard Oil Co., 332 U.S. 301 314-15 (1947); United States v. Jones, 264 F. Supp. 11, 15 (E.D. Va. 1967). Of course, the proposed legislation might also be justified as a regulation of a business in or affecting interstate commerce, see Maryland v. Wirtz, 392 U.S. 183 (1968); United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944), if further constitutional support were thought necessary.

Subsequent communications from the Department of Justice have echoed this opinion.

In its February 26, 1985, report entitled "Legislation To Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings," the General Accounting Office concluded that application of legislation such as S. 759 would not violate due process. In support of its opinion, GAO quoted an April 1979 letter to the Chairman, Senate Veterans' Affairs Committee, from the Assistant Attorney General, who in commenting on S. 759 discounted the argument that the legislation would have a constitutionally prohibited retroactive effect:

> The retrospective aspects of this bill therefore are neither "manifestly unjust" nor "particularly harsh and oppressive"; to the contrary everything has been done to protect the insurance carriers' reasonable interest.

GAO Report, p. 43

Nevertheless, it has been argued that a requirement for the elimination of these exclusions from "guaranteed renewable" policies (those policies for which the carrier's only option, if the insured chooses to renew, is to modify the applicable premium) violates the due process clause of the fifth amendment of the Constitution. This position appears to be based upon the decision by the Court of Appeals of New York in Health Ins. Ass'n. of America v. Harnett, 44 N.Y. 2d 302, 405 N.Y.S. 2d 634 (1978). There, the court held that a recently enacted State statute mandating the inclusion of maternity care coverage in health and accident insurance policies was unconstitutional as applied to guaranteed renewable policies. The court based its decision on article I, section 10, of the United States Constitution which prohibits the states from passing any law which would impair the obligations of contracts. However, the contracts clause has no application to the Federal Government. Century Arms, Inc. v. Kennedy, 323 F. Supp. 1002 (D. Vt. 1971), aff'd., 449 F.2d 1306 (2d Cir. 1971), cert. den., 405 U.S. 1065 (1972).

Reliance upon the Harnett case is therefore inappropriate. Indeed, in that case, the court specifically held that the statute under challenge complied with due process of law as required by the fourteenth amendment. Thus, the case lends support to the position that the proposed legislation is constitutional under the due process clause of the fifth amendment. See also St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531 (1978); Hewlett & Packard Co. v. Barnes, et al., 571 F.2d 502 (9th. Cir. 1978); and Insurers' Action Council, Inc. v. Heaton, 423 F. Supp. 921 (D. Minn. 1976).

McCarran-Ferguson Act

While not a constitutional issue, it has also been argued that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, generally leaving to the States the regulation of insurance, would conflict with the proposed exclusionary clause legislation. However, section 1012(b) of the Act excepts Federal laws which specifically relate to the business of insurance. Congress did not grant the States an exclusive right over the regulation of the business of insurance:

> States have power, under the Act, to regulate the insurance business within reasonable bounds, as limited by United States Supreme Court decisions, and within the limits laid down by Congress in the Act . . . .
>
> The Act did not, in common parlance, grant the states any power, but left them with the indigenous power they then possessed unaffected

> by reason of the commerce clause of the United States Constitution except to the extent provided in the Act . . . .
>
> . . . .
>
> As a general rule, where there is an applicable state statute, federal legislation does not apply to the insurance business under the McCarran-Ferguson Act (15 USC §§ 1011-1015), unless the federal legislation invalidates, impairs, or supersedes the applicable state statute . . . .

21 L. Ed. 2d 950, 951 (citations omitted)

There is, therefore, no conflict between the proposal and the McCarran-Ferguson Act.

Eminent Domain

Finally, objections to exclusionary clause legislation have been lodged in terms of it violating the "basic principle" that insurance should not have to cover charges for which the policyholder has no legal obligation to pay.

The most recent formulation of this argument is that the proposed legislation would work an unconstitutional "taking" of property for a public purpose without just compensation in violation of the fifth amendment's limitation on the Government's power of eminent domain. The argument totally ignores the fact that veteran policyholders are being compensated by receiving medical care in a VA medical facility. The legislation would merely require the insurers to pay for the cost of care provided to their policyholders; care for which premiums have been paid. The fact that the Government does not choose to charge and collect from the veterans themselves for deductibles, co-payments, or other portions of medical bills not covered by insurance gives no cause for complaint by the insurers and certainly none by the veterans.

In this regard, the proposed legislation is similar to the Federal Medical Care Recovery Act (FMCRA) and 38 U.S.C. § 629, both of which create an independent right in the Government to collect its medical care costs in certain circumstances despite the lack of an obligation to pay on the part of the recipient of the care. Both have been upheld by the courts. United States v. Jones, 264 F. Supp. 11 (E.D. Va. 1967) (FMCRA held constitutional); United States v. State Farm Insurance Company, 599 F. Supp. 441 (E.D. Mich. 1984) (Section 629 preempts state no-fault law to the extent it would prevent reimbursement to VA).

The analogy to the FMCRA is an apt one. The act was passed following the Supreme Court's decision in United States v. Standard Oil Co., 332 U.S. 301 (1946), where the Court held that, absent a statute, the Government could not recover its cost of treating a soldier injured as the result of another's negligence. In so holding, however, the Court made it clear both that Congress had the power to authorize such recoveries through legislation and that this power was not limited to the tort context, stating:

> For grounded though the argument is in analogies drawn from that field [tort], the issue comes down in final consequence to a question of federal fiscal policy, coupled with considerations concerning the need for and the appropriateness of means to be used in executing the policy sought to be established. The tort law analogy is brought forth, indeed, not to secure a new step forward in expanding the recognized area for applying settled principles of that law as such, or for creating new ones. It is advanced rather as the instrument for determining and establishing the federal fiscal and regulatory policies which the Government's executive arm thinks should prevail in a situation not covered by traditionally established liabilities.

> Whatever the merits of the policy, its conversion into law is a proper subject for congressional action, not for any creative power of ours. Congress, not this Court or the other federal courts, is the custodian of the national purse. By the same token it is the primary and most often the exclusive arbiter of federal fiscal affairs. And these comprehend, as we have said, securing the treasury or the government against financial losses however inflicted, including requiring reimbursement for injuries creating them, as well as filling the treasury itself.

332 U.S. at 314-315

After passage of the FMCRA, the U.S. District Court for the Eastern District of Virginia in United States v. Jones, supra, commented:

> It took Congress fifteen years to fill the gap occasioned by United States v. Standard Oil Co., 332 U.S. 301, 67 S.Ct. 1604, 91 L.Ed. 2067 (1947), wherein the Supreme Court ruled that only Congress had the power to create a parallel right of action to recover amounts expended for hospitalization by reason of injuries received as the result of negligence of a third party. To now hold that the Federal Medical Care Recovery Act is unconstitutional would, in effect, be tantamount to disregarding the language of the Supreme Court in its 1947 opinion heretofore mentioned.

264 F. Supp. at 14

Similarly, in United States v. State Farm Ins. Co., supra, the court had no difficulty in articulating a valid Federal purpose for the Government's pursuit of recovery under a no-fault policy pursuant to 38 U.S.C. § 629:

> Moreover, the Government's action is fashioned to prevent the insurance carrier from unjustly benefiting from the fortuitous circumstance of Mytty's veteran status. The Government has provided medical care and services to Mytty at a significant cost to the taxpayers. But for Mytty's status, State Farm would have been bound to pay for that care from the outset. The insurance premiums paid by Enio Mytty were assessed with a view toward the risk of an accident such as the one presented here. State Farm's failure to pay for the reasonable value of the services rendered by the VA has unjustly enriched the insurance carrier and significantly burdened the taxpayers. This is a classic case of unjust enrichment . . . .

599 F. Supp. at 446

Again, the February 1985 GAO report concluded that the absence of an obligation to pay on the part of the veteran is no obstacle to the Government's entitlement to reimbursement when the authorizing legislation gives the Government an independent Federal right of recovery.

Summary

There are no genuine constitutional issues raised by the proposed exclusionary clause legislation. Due process objections lodged against earlier versions of the proposal based upon possible retroactive effects have been met with provisions for assuring only prospective application of the legislation. There is no conflict with McCarran-Ferguson since the law would specifically relate to insurance. The eminent domain argument is essentially frivolous. Cases cited in support of the argument have been researched and capsulized in the attached appendix. They simply have no relevance to the issue of Federal authority to recover from private insurers the cost of care furnished to veterans. There is ample precedent in the cases upholding the FMCRA and 38 U.S.C. § 629 to support the conclusion that the proposed legislation would be found constitutional.

ROBERT E. BROYLES
Staff Attorney (021C1) Date: April 22, 1985

E. DOUGLAS BRADSHAW, Jr.
Deputy Assistant General Counsel (021B) Date: April 22, 1985

Appendix

Webb's Fabulous Pharmacies, Inc. v. Beckwith, 449 U.S. 155 (1980)

County's taking, pursuant to Florida law, of interest accruing on interpleader fund deposited in county court, was a taking in violation of the 5th amendment, applicable to the states through the 14th amendment, where there was a separate law that authorized a clerk's fee based upon the amount of the principal sum deposited, the deposited fund itself was private, and the deposit in the court's registry was required by State law if the depositor was to protect himself by filing the interpleader.

Penn Central Transp. Co., v. New York, 438 U.S. 104 (1978)

The Grand Central Terminal, owned by Penn Central Transportation Company, was designated an historic landmark. Thereafter, it was leased to UGP properties which planned to build a multistory office building over the terminal. The Landmarks Preservation Commission rejected these plans and suit followed.

The Supreme Court affirmed the lower court and held that, although the 5th amendment's prohibition against an unjust taking of private property without just compensation is applicable to the states through the 14th amendment, the Government may execute programs adversely affecting recognized economic values without such act being a "taking"; that the character of the action and nature and extent of the interference with property rights are focused upon rather than discrete segments; that diminution in property value alone cannot establish a taking nor regulation of individual landmarks; that although the Landmarks Law affects some landowners more than others, the preservation benefits the citizenry economically and improves the overall quality of city life; that this law is similar to zoning and merely prohibits occupying certain features of space while allowing use of the remainder; and that there is no interference with the present use of the property.

Goldblatt v. Town of Hempstead, 369 U.S. 590 (1962)

Suit to enforce an ordinance prohibiting excavations below 2 feet above maximum ground water level. The defendants, who were engaged in dredging and pit excavation, asserted that the ordinance was an unlawful taking of their property.

The Supreme Court affirmed the lower court's finding that the ordinance was a valid exercise of the town's police power under the fifth amendment to the U.S. Constitution.

Armstrong v. United States, 364 U.S. 40 (1960)

Unpaid materialmen whose supplies went into the construction of vessels for the Government which appropriated them upon the contractor's default were entitled to compensation under the fifth amendment. The Court of

Claims decision that it was a public work immune from materialmen's liens was reversed by the Supreme Court.

United States v. Causby, 328 U.S. 256 (1946)

An airport was leased to the Government which scheduled frequent flights of Army and Navy planes at a low altitude over a chicken farm, rendering it unsuitable for that use. The farmer, alleging an unconstitutional taking, obtained judgment in his favor in the Court of Claims. On appeal, the Supreme Court agreed with the finding of the Court of Claims that the frequent, low-level, flights were a direct and immediate interference with the enjoyment and use of the land, but reversed the award of damages and remanded the case for findings as to the permanency of the easement taken by the Government.

Hadacheck v. Sebastian, 239 U.S. 394 (1915)

Owner of brick making business was prohibited from operation after his property became annexed to the city of Los Angeles.

The Court held that the municipal ordinance enacted as a police measure did not take property without due process of law under the fifth Amendment to the U.S. Constitution.

Pennsylvania Coal Co. v. Mahon, 260 U.S. 393 (1922)

Land was sold subject to the right of mining coal upon which a residence was erected. A statute was subsequently passed which prohibited mining under such structures and the owners of the residence sued for an injunction to stop the mining operation. The Supreme Court of Pennsylvania found the statute a constitutional exercise of the State's police power, but the Supreme Court reversed, holding that the statute was unconstitutional as a taking of property (the right to mine coal) without due process of law.

Mugler v. Kansas, 123 U.S. 623 (1887)

Kansas enacted a law prohibiting the manufacture and sale of intoxicating liquors. The plaintiffs alleged that their buildings were erected for the manufacture of liquor before passage of the law and thereby became useless.

The Supreme Court held that a prohibition on the use of property that would injure the health, morals, or safety of the community is not an unlawful taking of property under the 14th amendment to the U.S. Constitution.

Pumpelly v. Green Bay & Miss. Canal Co., 80 U.S. (13 Wall.) 166 (1871)

A dam was built on a navigable stream raising its level and causing it to overflow and flood the land of another.

The Supreme Court held that the superinduced additions of water and earth effectually destroyed its usefulness and was a taking within the meaning of the Constitution.

United States v. United Services Automobile Assn., 431 F.2d 735 (5th Cir. 1970)

Suit was brought under medical payment provision of automobile policy for costs of medical expenses. The court interpreted policy to include the Government as a third party beneficiary.

GEICO v. United States, 376 F.2d 836 (4th Cir. 1967)

An Army officer's son was injured in an automobile accident. The tort feasor was uninsured but the son recovered under the no-fault policy of the automobile in which he was riding as a passenger. The insurer denied payment to the Government for medical expenses.

The court held that the Government's right to recover was based upon the policy provision that one entitled to recover from the uninsured third party is in turn entitled to payment as an insured.

United States v. Jackson, 572 F. Supp. 181 (W.D. Mich. 1983)

Suit under the Federal Medical Care Recovery Act (FMCRA) against automobile driver's no-fault insurance and the owner of a bar which allowed the tort feasor to become intoxicated.

Court held that FMCRA applies under circumstances creating a tort liability and under Michigan no-fault law, tort liability was extinguished.

The court also found that the Government was not a third party beneficiary to the no-fault policy in view of the express language of State law prohibiting recovery by the Federal Government.

United States v. Allstate, 306 F. Supp. 1214 (N.D. Fla. 1969)

Suit was filed to recover medical expenses under an uninsured motorist policy of insurance. The court held that the Government was not an insured as defined in the policy, distinguishing *Geico v. United States*, 376 F.2d 836 (4th Cir. 1967), due to the express language of the policy which defined "insured" to include only the policyholder, relatives and residents of his household, and occupants of the policyholder's vehicle.

NOTE: There was no Federal law such as 38 U.S.C. § 629 authorizing recovery in this case. The injured party was a seaman, not a veteran. Since then, *United States v. State Farm Ins. Co.*, 599 F. Supp. 441 (E.D. Mich. 1984), which concerned a veteran, has upheld 38 U.S.C. § 629.

RESPONSE OF THE GENERAL ACCOUNTING OFFICE TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A.

On page 1 of your statement, you note that "about 18 percent of the episodes [of VA care among those in the study cohort] were provided to veterans who had health insurance."

> What was the breakdown among those with insurance as between those with comprehensive, high option insurance and those with low option or other less comprehensive policies?

Answer 1A.

The 18 percent included only episodes of care provided to veterans with comprehensive hospitalization insurance. We excluded episodes of care provided to veterans whose coverage was limited to a Medicare supplement, a policy that paid cash when the policyholder is hospitalized, or other less comprehensive insurance, such as cancer and black lung policies. The number of questionnaire respondents having such coverage is shown on page 14 of our report.

Question 1B. What steps did you take to verify that the veterans were carrying the insurance they reported and that the insurance would actually have covered some or all of the cost of the care they received from VA?

Answer 1B.

Our questionnaire asked veterans to provide the name of their health insurance plan and their policy number. In two states, we validated the reliability of the veterans' questionnaire responses regarding private health insurance coverage against answers from the veterans' employers. The results of the validation effort confirmed that the veterans' answers to the questionnaire were generally accurate and conservative.

To determine whether the veterans' insurance would have actually covered all or some of the cost of their care, we asked veterans whether they knew of any reasons why their insurance would not have covered their non-service-connected care. We followed up with veterans by telephone where their answers were not clear.

Question 2.

In selecting your sample of 685,000 episodes of care, did you exclude veterans with any service-connected disabilities, including those with non-compensable ratings, the so-called "zero-percenters"?

Answer 2.

We excluded episodes of care provided for service-connected disabilities, but did not exclude non-service-connected episodes of care provided to service-connected veterans. Specifically, we excluded from our universe veterans who (1) had a service-connected rating of 50 percent or more or (2) had a service-connected rating of less than 50 percent but were, according to VA's patient treatment records, treated for a service-connected disability. We made further revisions to our universe based on veterans' questionnaire responses about their service-connected status.

Question 3.

On page 4 of your testimony, you state that for each $100 million in VA recoveries, "premiums for each of the 112 million policyholders would have increased [in fiscal year 1982] by about one dollar." I assume your estimate of $1 per policyholder is meant as an average. Do you agree with the point HIAA makes in its testimony that some premiums--such as those for insurers in the vicinity of VA health care facilities--will increase to a substantially greater degree.

Answer 3.

We stated in our report (p. 35) that the effects of the small premium increases from payment of non-service-connected VA care may vary according to the concentration of veterans covered by individual policies. However, we do not believe such variations would be so great as to affect employers' willingness to offer health insurance to their employees or veterans' desire and ability to purchase insurance for themselves and their families. A more detailed discussion is contained in our June 25, 1985, letter to Chairman Murkowski analyzing a similar Blue Cross and Blue Shield Association comment on our February 26, 1985, report.

Question 4.

On page 6 of the HIAA testimony, the concern is raised that providing for full reimbursement to the VA of the costs of care provided to veterans without subjecting the VA to standard utilization reviews and other cost containment measures will not permit insurance carriers to exert appropriate influence on excessive lengths of stay within the VA. In light of the findings in your draft report, that there are significant excess lengths-of-stay in the VA, do you agree with HIAA's concerns in this regard?

Answer 4.

We agree that health insurers should have the same rights to perform utilization reviews of VA facilities as they do to review private sector facilities. Regarding the application of cost containment provisions, such as mandatory ambulatory surgery and second surgical opinion programs, it should be noted that VA recoveries would be contingent upon their compliance with policy provisions. Our June 25, 1985, letter to Senator Murkowski provides a further discussion.

Question 5.

HIAA in its statement notes that

> "Insurers reap no extra benefit or profit [the exclusion of reimbursement for care in the VA] because insurance premium rates are calculated to reflect actual claims experience and utilization.

This statement directly rebuts the so-called "windfall" theory which holds that insurers have been charging veterans premiums for care that has not been covered. I was satisfied when this issue was before the Committee in 1980 that there was no validity to the windfall theory but have again seen and heard references to it during the current debate on this issue. Is it clear to you that there is no validity to the windfall theory?

Answer 5.

Our report recognizes that most health insurance is experience-rated. Under experience rating, any savings that accrue to insurance companies because they do not have to pay claims for care provided in VA facilities should be passed on to policyholders in the form of lower premiums.

Question 6(1).

In its testimony, HIAA describes various efforts that health insurers currently have underway to reduce health-care costs, including "preadmission review and certification, establishment of appropriate length of stay prior to admission, concurrent review of utilization, post admission audits to verify the propriety of services and second opinions for elective surgery.

In your view, how could the VA, without accepting such controls from insurance carriers, submit valid claims under the terms of insurance contracts which require compliance with those controls as a condition of payment?

Answer 6(1).

As previously mentioned, VA could not obtain reimbursement from private health insurance unless it complied with policy provisions.

Question 6(2). Do you believe VA will accept these controls?

Answer 6(2).

The administration's legislative proposal specifically provides for insurance companies' access to VA clinical records. We are optimistic that VA will accept the provisions of private health insurance policies and that this will result in further cost savings.

Question 7.

Please submit any documents which relate to your authority to utilize IRS data for analysis of veterans' income described on page 5 of your testimony.

Answer 7.

GAO evaluators were designated as agents of the House Committee on Ways and Means for the purpose of conducting the study. Appropriate correspondence on this designation is attached.

Question 8.

Attached is a July 2, 1980, letter from the Disabled American Veteran's national director of services which encloses a VA document that discusses the VA's then current estimate of the cost impact of third-party reimbursement legislation. Please review this material, discuss it with appropriate VA officials, and provide your views on it.

Answer 8.

One of the principal reasons that we initiated the review that resulted in our February 1985 report was the concern expressed by the Committee that VA's prior estimates of potential savings and administrative costs involved in VA's operation of a third-party recovery program were not soundly based. Our analysis of VA's prior estimates is included in our report. In commenting on our report, VA stated that it supports recovery legislation and in its June 1985 testimony before the Committee, stated that it now believes enactment of such legislation could result in reimbursements ranging from $65 million in fiscal year 1986 to $285 million in fiscal year 1990.

[illegible]

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

TELEPHONE (202) 225-3625

July 14, 1981

Mr. Milton J. Socolar
Acting Comptroller General
of the United States
U. S. General Accounting Office
441 G Street, N. W.
Washington, D. C. 20548

Dear Mr. Socolar:

Over the years, the General Accounting Office (GAO) has reviewed the efficiency and effectiveness with which Executive departments and agencies carry out programs authorized by the Congress. In doing so, GAO has identified and analyzed a wide range of issues and, perhaps even more importantly, has provided an oversight capability that is not available to the Congress elsewhere.

It has come to my attention that the Internal Revenue Service (IRS) has adopted an interpretation of those provisions of the Internal Revenue Code regarding GAO access to tax return information that could limit GAO's effectiveness. Specifically, IRS maintains that unless GAO is (1) acting as an agent of certain Committees pursuant to 26 U.S.C. 6103(f), (2) undertaking a review of IRS or the Bureau of Alcohol, Tobacco, and Firearms of the Department of Treasury pursuant to 31 U.S.C. 67(d), or (3) conducting an audit of security procedures authorized by 26 U.S.C. 6103(p)(6), GAO is not entitled to access to returns and return information. The strict implementation of IRS' view, for example, impacts on numerous on-going and planned GAO reviews at the Social Security Administration and the Health Care Financing Administration--organizations which utilize return information in their execution of various Federal programs. Without complete access to such files, GAO would be hampered, if not totally frustrated, in its efforts to review the administration of the programs.

In view of the above and in order for GAO to continue its important functions, I designate your office as the Committee's agent, pursuant to the provisions of section

6103(f)(4)(A) of the Internal Revenue Code, 26 U.S.C. 6103(f)(4)(A). In this capacity, GAO staff assigned to specific audits are authorized access to tax returns and tax return information for the purposes of reviewing any Federal program where such information is or could be used to establish eligibility, administer the distribution of program benefits, or to otherwise determine whether Federal programs are being carried out as intended by the Congress. The Committee recognizes that this information is an integral part of most reviews of Federal entitlement programs including retirement, pension, disability, and related compensation programs, as well as most needs-based programs where recipients' income, assets, or other resources are used to determine their eligibility or payment amount.

In carrying out their work pursuant to this agency designation, it is understood that GAO staff will be subject to existing legislative restrictions on public disclosure. Also, the Comptroller General (or his designee, not lower than the Associate Director level) will be expected to authorize in a letter to this Committee, those individual projects where the need for access to tax information is anticipated. Upon the expiration of a twenty day period after such notice is received by the Committee, the project(s) will be considered "authorized" by the Committee, unless during this period the Comptroller General is formally notified that the Committee does not wish the audit to proceed.

Further, it is understood that you will be authorizing projects based on your internal planning system or identified through expressions of interest by other Committees and Members of Congress. The Committee does not object to GAO communicating--as it deems appropriate--the progress or results of such work as long as there is no disclosure of tax returns or return information.

This is intended to be a temporary resolution of GAO's status under the Code's disclosure provisions until a legislative solution can be effected.

With warm regards, I am

Sincerely yours,

Dan Rostenkowski
Chairman

DR/mwl

NINETY-SEVENTH CONGRESS
DAN ROSTENKOWSKI, ILL., CHAIRMAN
[illegible]

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

TELEPHONE [illegible]

October 5, 1982

The Honorable Charles A. Bowsher
Comptroller General
of the United States
U. S. General Accounting Office
441 G Street, N. W.
Washington, D. C. 20548

Dear Mr. Bowsher:

The Commissioner of Internal Revenue recently requested clarification of the Committee on Ways and Means' July 14, 1981 letter designating the General Accounting Office as agent of this Committee, pursuant to Internal Revenue Code Section 6103(f)(4)(A), for tax disclosure purposes. I am enclosing a copy of my response to the Commissioner for your information.

I would also like to take this opportunity to discuss with you directly the effect of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) on the July 14, 1981 designation letter and GAO's access to tax returns and return information.

It is clear from the actual terms of the letter that the July 14, 1981 agency designation was designed to be a temporary resolution of GAO's status under the disclosure provisions of the Code pending a legislative solution. That legislative solution has been effected by Section 358 of the Tax Equity and Fiscal Responsibility Act of 1982. In this regard, the Conference Report to accompany the Act provides, at page 677, that "...the GAO may continue audit activity, which involves access to tax information, pursuant to any current agency designation, which is in process as of the date of enactment."

Therefore, GAO's disclosure authority under this Committee's July 14, 1981 agency designation letter continues only with respect to those audits and reviews in process, pursuant to that designation, as of September 3, 1982, the date of enactment of the Tax Equity and Fiscal Responsibility Act of 1982. The July 14, 1981 designation letter is null and void as to all future GAO reviews and audits. All future GAO access to tax information shall be governed exclusively by Code Section 6103(i)(7), specific designations of agency under Section 6103(f)(4)(A) of the Code, or other provisions of law.

I hope this information is helpful to you.

Sincerely,

Dan Rostenkowski

Dan Rostenkowski
Chairman

DR/rgl

Enclosure

Chairman MURKOWSKI. I would like to thank the majority and minority staffs and counsel and those who have been with us throughout the morning since 9:30, and all of the witnesses who testified previously.

The Chair will hold the record open for about 10 days unless there is any reason to consider further on it.

Do you have any comments on the timeframe, Jon?

Mr. STEINBERG. We would like to receive responses back from the VA.

Chairman MURKOWSKI. Yes. We would like to see the VA responses, obviously.

I would again tell you that I think the highlight of what has come out of this hearing is the anticipation by those of us who will not be a party to the meeting. As a consequence, we look forward with great faith in the system working. We will be disappointed if it does not work. But in the meantime, we will look forward to having some kind of hopefully positive response from that meeting that will address the question that is before us and that is, are we simply pursuing a cumbersome process and going to make it more cumbersome, or are we in reality pursuing a worth while effort that can basically utilize the funding in a more efficient manner.

I will look forward to having my staff advise me of when that meeting is going to be held. We would appreciate if those whose names that were indicated would make themselves available.

I would suggest that you put a time limit on your meeting with the idea of reaching a conclusion prior to the end of that timeframe and that be the basis of your intention in going into the meeting. I guess we will see which side prevails.

Thank you very much.

Mr. FOGEL. Thank you, Mr. Chairman.

Chairman MURKOWSKI. The meeting is recessed, adjourned, or otherwise.

[Whereupon, at 12:37, the committee was adjourned.]

[The committee received the following letters and statements for the hearing record:]

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
FOUNDED 1899

OFFICE OF
DIRECTOR, NATIONAL LEGISLATIVE SERVICE

V. F. W. MEMORIAL BUILDING
200 MARYLAND AVENUE, N. E.
WASHINGTON, D. C. 20002

June 14, 1985

The Honorable Frank H. Murkowski
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

It is my understanding that during the second hearing with respect to the Administration's proposed health-care policy changes scheduled for June 20, 1985, your Committee intends to consider permitting to expire with the current fiscal year the extraordinary waiver authority with respect to the number of veterans who may be provided contract health care by the Veterans Administration in Puerto Rico. Quite frankly, Mr. Chairman, we view such an abrupt termination an insensitive disservice to veterans who are, lest we forget, United States citizens.

As you are aware, one of the provisions of H.R. 505 passed by the House of Representatives on May 21, 1985, would extend until September 30, 1988, the authority of the Veterans Administration to contract for care of nonservice connected veterans in Puerto Rico and the Virgin Islands and, also, provides for a three year phase-out in Puerto Rico of the so-called "extraordinary authority." We believe this to be a much more satisfactory way to deal with the situation and one which would be consistent with the planned improved capability of the Veterans Administration to provide necessary health care. The VFW supports this position and urges similar action by your Committee with the caveat that the recommendations made in the Veterans Administration's report entitled "Health Care Plan for Veterans in Puerto Rico and the Virgin Islands," dated April 30, 1985, are timely implemented.

With best wishes and kind personal regards, I am

Sincerely,

Donald H. Schwab
DONALD H. SCHWAB, Director
National Legislative Service

cc: The Hon. Alan Cranston
Ranking Minority Member

The American Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

June 11, 1985

Honorable Frank H. Murkowski
317 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Murkowski:

With the understanding that you have rescheduled the second of two hearings on health legislation and a variety of proposals made by the Administration, The American Legion requests that this letter and attached memorandum on one of these proposals be placed in the hearing record. At the time of the first of the two hearings at which we presented testimony, no comment was made in our statement concerning the extension of contract authority for care of veterans in Puerto Rico and the Virgin Islands.

This attached memorandum expresses our support for extending contract authority to September 30, 1988 as requested by the Administration. That support notwithstanding, the needs of veterans in Puerto Rico and the Virgin Islands are great and must ultimately be attended to in a fashion reaching beyond stop-gap extensions of contract authority.

As always, your attention to the views of The American Legion are appreciated.

Sincerely,

Paul S. Egan, Deputy Director
National Legislative Commission

THE AMERICAN LEGION
1608 K STREET, N.W.
WASHINGTON, D. C. 20006

Memorandum to: PAUL EGAN, Deputy Director
National Legislative Commission

DATE: June 7, 1985

SUBJECT: Extension of Contract Authority for Provision of Medical Care to Veterans in Puerto Rico and the Virgin Islands

This is in response to the request by the Senate Committee on Veterans Affairs for the position of The American Legion on the Administration's proposal to extend the contract authority for the provision of medical care to veterans residing in Puerto Rico and the Virgin Islands until September 30, 1988.

The American Legion has recognized, identified, and attempted to deal with the problems that exist in the provision of health care in Puerto Rico for over twenty years. At least six official visits by American Legion representatives have been conducted for the purpose of assessing the inherent problems of health care delivery to veterans, and reiterating the urgency of this situation to the Veterans Administration and the Congress.

Within recent years, at the request of Congress, the Veterans Administration conducted a study of these health care delivery problems and prepared a report entitled "A Plan for the Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands." Without going into great detail at this time, it should be pointed out that the VA study describes the foregoing problems, and contains recommendations that, if initiated, would alleviate many of the difficulties, and go far in accomplishing a comprehensive plan for providing appropriate and cost-effective health care to the veterans in Puerto Rico and the Virgin Islands.

The American Legion supports the extension of the VA's authority to provide contract care and fee-basis medical services. However, we would urge that the Congress and the Veterans Administration consider the situation that continues to exist, as well as the data amd recommendations contained in the VA study. The problems that exist in Puerto Rico are real, and they need to be addressed.

John Sommer
JOHN F. SOMMER, JR.
Deputy Director
National Veterans Affairs and
Rehabilitation Commission

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

July 11, 1985

Honorable Frank H. Murkowski
Chairman
Senate Veterans Affairs Committee
709 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Murkowski:

The purpose of this correspondence is to convey the views of the Disabled American Veterans pertaining to a legislative proposal that, if enacted, would permit the Veterans Administration to collect the cost of hospital, nursing home or outpatient medical care furnished by that agency to veterans who have private health insurance.

As you will recall, from our May 7, 1985, written testimony concerning the Committee's legislative hearing on certain issues pertaining to veterans' health care, including third party reimbursement, we expressed our disappointment that we had not been furnished a copy of the proposed legislation for review. Additionally, we requested the opportunity to express our position at a subsequent hearing or in written form following our detailed review and analysis of the proposal.

We have now had a chance to review the Administration's proposal and would like to submit our comments for the record.

Mr. Chairman, the DAV remains totally and adamantly opposed to any proposal that would give the VA the right to recover the cost of medical care furnished by the VA to veterans with no service-connected disabilities to the extent that they have private health insurance or similar medical coverage.

Medical care provided to this nation's veterans by the Veterans Administration has been a time-honored and readily bestowed benefit provided by Congress via the wishes and intentions of a grateful American public. Making the provision of VA health care a "cost-sharing venture" would go against the grain and intent of the program and, in our opinion, the desires of a grateful nation.

We feel that should this proposal be enacted into law, it would surely act as the precursor to a merging of the VA health care system into a national health care program whereby disabled veterans would be required to pay for their needed medical care. Also, a degree of discrimination may very well exist wherein the admittance to a VA facility of a nonservice-connected veteran with health insurance may take precedence over the admittance of an as needy or more needy veteran without such similar coverage.

The proposal to enact third party reimbursement immediately brings to mind many serious questions, such as:

* would the overall cost of national health care increase without improvement in the quality of care furnished?

* would a significant, adverse change in the character and mission of the VA health care system be forthcoming?

* would the much needed and desired health care cost containment efforts on a national level be diminished?

* would the administrative burden imposed on the VA to effectuate billing procedures acceptable to the insurance industry be overwhelming?

* would resources designated for health care purposes be shifted to accommodate billing procedures and administrative tasks?

* would costly and time consuming litigation occur which may, in turn, lead to an exorbitant amount of resources being expended and delays encountered before the VA receives any reimbursement?

* is the assumption regarding the extent of insurance coverage of veterans receiving VA care and the potential recovery accurate or, as we believe, highly speculative and inaccurate?

Considering the indigent nature of most VA inpatients, in conjunction with a "means test" that may be administratively or statutorily imposed, it is our view that the majority of veterans treated in VA medical facilities test from whom third party reimbursement could be collected would, at best, be negligible. Therefore, potential cost recoveries under this proposal would seem to be virtually negated.

Mr. Chairman, we certainly appreciate your consideration of our comments regarding this issue and again request that this correspondence be made a part of the official June 20, 1985, hearing record of the Committee.

Sincerely

Dave W. Gorman

DAVID W. GORMAN
Assistant National Legislative Director
for Medical Affairs

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

PREPARED STATEMENT OF
BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR
SUBMITTED FOR THE RECORD
TO THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
HEALTH CARE IN PUERTO RICO
JUNE 20, 1985

Mr. Chairman and Members of the Committee, Paralyzed Veterans of America is grateful for this hearing which demonstrates the Committee's continuing concern for the current and future health care needs of our nation's veterans, and appreciates the opportunity to submit its views on the "Veterans' Administration Health Programs Extension Act of 1985" as it pertains to the health care needs of veterans residing in Puerto Rico.

Our concern is to secure for those veterans living in Puerto Rico, the same quality of health care that veterans living on the mainland receive. PVA has an active Chapter in Puerto Rico, whose members have all experienced spinal cord injury or dysfunction.

The "Veterans Administration Health Care Programs Extension Act of 1985" would extend for an additional three years, through September 30, 1988, the VA's authority to provide contract hospital care, and outpatient care that will obviate the need for hospital admission, to certain veterans in Puerto Rico. The VA has submitted reports to Congress regarding the planning for meeting the health care needs of these veterans. We envision the process of

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300

establishing an equitable mechanism for responding to the needs of veterans in Puerto Rico to be a lengthy one. Therefore, we believe this three-year extension is needed to prevent any unnecessary hardship on veterans in Puerto Rico and to give the VA and the Congress an adequate opportunity to achieve the mutual goals with respect to these veterans.

This proposal would also extend for three years, to September 30, 1988, the VA's pilot program to contract for care, treatment, and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. A study of the pilot program indicated that the contract authority has been and would continue to be a valuable, cost-effective modality to supplement VA treatment and rehabilitation of certain veterans.

This concludes PVA's statement and again we appreciate the opportunity to submit our views.

APPENDIX

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

September 27, 1985

Honorable Pete V. Domenici, Chairman
Honorable Lawton Chiles, Ranking Minority Member
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Pete and Lawton:

Pursuant to section 2(1) of Senate Concurrent Resolution 32, the First Concurrent Resolution on the Budget for Fiscal Year 1986, and action of the Committee at a September 26, 1985, meeting, the Committee on Veterans' Affairs is submitting to the Budget Committee the enclosed legislation and report recommending budget savings. The reconciliation instructions contained in section 2(1) of S. Con. Res. 32 require this Committee to report changes in laws within this Committee's jurisdiction sufficient to reduce both budget authority and outlays for veterans' programs by $300 million in fiscal year 1986, by $400 million in fiscal year 1987, and by $450 million in fiscal year 1988.

In order to meet these requirements, our Committee, by a 9 to 3 vote, makes the following recommendations in the enclosed legislation: First, to revise certain VA health-care eligibility criteria and to provide for certain veterans with substantial incomes to make modest payments for VA care furnished for non-service-connected disabled veterans (Part A); second, to authorize the United States to recover from health insurers certain reasonable costs of care and services furnished through VA facilities or non-VA facilities at VA expense for veterans with no service-connected disabilities who are covered under health-plan contracts (Part B); and third, to restrict the FY 1986 disability compensation/DIC COLA rate increase to the 3.7 percent estimated as the forthcoming Social Security benefit COLA (Part C). We believe that these recommendations provide the most reasonable means for the Committee to comply with our reconciliation instructions in S. Con. Res. 32.

Estimated savings resulting from enactment of the legislation we are submitting would exceed the three-year total of $1.15 billion in required reconciliation savings by $150 million. The Committee legislation would achieve net savings of $1.3 billion in budget authority and outlays over fiscal years 1986 through 1988, according to CBO estimates, approximately $1.1 billion of which is through increased revenues to be deposited directly in the Treasury in order to reduce the deficit.

We have also enclosed report language and a section-by-section analysis which explain our reconciliation legislation in greater detail as well as a cost estimate prepared by the Congressional Budget Office.

The Committee's reconciliation legislation demonstrates our Committee's commitment to reducing our national deficit while continuing to provide fair and equitable treatment to the veterans of our Nation.

Sincerely,

Frank H. Murkowski
Chairman

Alan Cranston
Ranking Minority Member

Enclosures

TITLE XI -- VETERANS' PROGRAMS

PART A -- ENTITLEMENTS AND ELIGIBILITIES FOR HEALTH CARE FROM THE VETERANS' ADMINISTRATION

ENTITLEMENT AND ELIGIBILITY FOR HOSPITAL CARE

SEC. 1101. Section 610(a) is amended by striking out "(a)" and all that follows through "care;" at the end of clause (1)(B) and inserting in lieu thereof the following:

"(a)(1)(A)(i) Except as provided in division (ii) of this subparagraph, the Administrator, through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title, shall furnish such hospital care as the Administrator determines to be reasonably necessary for--

"(I) a veteran for a disability rated as service connected; and

"(II) any disability of a veteran who has a service-connected disability rated at 50 percent or more.

"(ii) In the case of a veteran who is under incarceration, the Administrator (I) may decide not to furnish care under division (i) of this subparagraph in a Veterans' Administration facility if the Administrator determines that to do so would not be feasible in terms of the security necessary in connection with the custody of the veteran or the safety of other individuals receiving care in such facility, and (II) may furnish care under such division in a non-Veterans' Administration facility (as authorized in section 603 of this title).

"(B) The Administrator, through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title, may furnish such hospital care as the Administrator determines to be reasonably necessary for--

"(i)(I) a non-service-connected disability of a veteran who has a service-connected disability rated at less than 50 percent;

"(II) a veteran who, but for the receipt of retired pay, would be entitled to disability compensation;

"(III) a veteran who is entitled to disability compensation pursuant to section 351 of this title or, but for a suspension pursuant to such section, would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is not limited in the judgment or settlement described in such section; and

"(IV) a veteran whose discharge or release from active military, naval, or air service was for a disability incurred or aggravated in line of duty;

"(ii) a veteran who is a former prisoner of war;

"(iii) a veteran exposed to a toxic substance or radiation, as provided in subsection (e) of this section;

"(iv) a veteran of the Spanish-American War, Mexican border period, or World War I; and

"(v) a non-service-connected disability of a veteran who is unable to defray the expenses of necessary care.

"(C) The Administrator, through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title, may (to the extent facilities and resources are otherwise available and subject to subparagraph (D) of this paragraph) furnish such hospital care as the Administrator determines to be reasonably necessary for a non-service-connected disability of a veteran who agrees to make payment to the United States under section 612B of this title in connection with such care.

"(D) The Administrator may prescribe regulations under which a veteran having an annual income above an amount specified in such regulations, or an estate with a corpus above an amount specified in such regulations, would not be eligible for care under subparagraph (C) of this paragraph. For the purpose of this subparagraph, the Administrator shall determine annual income in accordance with section 503 of this title and shall count as income of the veteran any income of a veteran's family member that would be taken into account under section 521(c) of this title.".

ENTITLEMENT AND ELIGIBILITY FOR NURSING HOME CARE

SEC. 1102. Section 610(a) is further amended by striking out "(2)" and all that follows and inserting in lieu thereof the following:

"(2)(A) The Administrator, through Veterans' Administration facilities or as provided in section 620 of this title, shall furnish such nursing home care as the Administrator determines to be reasonably necessary to a veteran for a service-connected disability.

"(B) The Administrator, through Veterans' Administration facilities or as provided in section 620 of this title, may furnish such nursing home care as the Administrator determines to be reasonably necessary to any veteran eligible for hospital care under subparagraphs (A) and (B) of paragraph (1) of this subsection for any disability other than a service-connected disability.

"(C) The Administrator, through Veterans' Administration facilities or as provided in section 620 of this title, may (to the extent facilities and resources are otherwise available and subject to subparagraph (D) of this paragraph) furnish such nursing home care as the Administrator determines to be reasonably necessary for a veteran eligible for hospital care under subparagraph (C) of paragraph (1) of this subsection who agrees to make payment to the United States under section 612B of this title in connection with such care.

"(D) The Administrator may prescribe regulations under which a veteran having an annual income above an amount specified in such regulations, or an estate with a corpus above an amount specified in such regulations, would not be eligible for care under subparagraph (C) of this paragraph. For the purpose of this subparagraph, the Administrator shall determine annual income in accordance with section 503 of this title and shall count as income of the veteran any income of a veteran's family member that would be taken into account under section 521(c) of this title.".

ELIGIBILITY FOR DOMICILIARY CARE

SEC. 1103. Section 610(b) is amended to read as follows:

"(b) The Administrator, through Veterans' Administration facilities, may furnish such domiciliary care as the Administrator determines to be reasonably necessary to a veteran who is in need of domiciliary care if the Administrator finds, pursuant to regulations which the Administrator shall prescribe, that such veteran is incapacitated from earning a living and has no adequate means of support.".

ENTITLEMENT AND ELIGIBILITY FOR AMBULATORY OR OUTPATIENT MEDICAL SERVICES

SEC. 1104. (a) Section 612 is amended--

(1) in subsection (a)--

(A) by amending the first sentence to read as follows: "(1) Except as provided in paragraph (2) of this subsection and in subsection (b) of this section, the Administrator, through Veterans' Administration facilities or through private facilities to the extent authorized by section 603 of this title, shall furnish such medical services as the Administrator determines to be reasonably necessary (A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or relased from the active military, naval, or air service), and (B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more.";

(B) in the second sentence by striking out "may" and inserting in lieu thereof a comma and "as part of medical services furnished under the preceding sentence, shall";

(C) by striking out the third sentence; and

(D) by inserting at the end the following new paragraph:

"(2) In the case of a veteran who is under incarceration, the Administrator (A) may decide not to furnish services under the first sentence of paragraph (1) of this subsection in a Veterans' Administration facility if the Administrator determines that to do so would not be feasible in terms of the security necessary in connection with the custody of the veteran or the safety of other individuals receiving care in such facility, and (B) may furnish services under such sentence in a non-Veterans' Administration facility (as authorized in section 603 of this title).";

(2) in subsection (f)--

(A) in the first sentence--

(i) by striking out "within the limits of Veterans' Administration facilities" and inserting in lieu thereof "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title";

(ii) by inserting "and" after the semicolon at the end of clause (1);

(iii) by striking out clause (2); and

(iv) by redesignating clause (3) as clause (2);

(B) in the second sentence by striking out "also" and inserting in lieu thereof "as part of medical services furnished under the preceding sentence"; and

(C) in the third sentence by inserting a comma and "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title," after "may";

(3) in subsection (g) by striking out "within the limits of Veterans' Administration facilities" and inserting in lieu thereof "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title"; and

(4) by striking out subsection (i) and redesignating subsection (j) as subsection (i).

(b) Section 612A is amended--

(1) in subsections (a) and (b)(1) by striking out "within the limits of Veterans' Administration facilities" and inserting in lieu thereof "through Veterans' Administration facilities"; and

(2) in subsection (e)(1) by striking out "sections 612(f)(2) and 601(4)(C)(ii)" and inserting in lieu thereof "sections 612(a)(1)(B) and 603(2)(A)".

PAYMENTS BY CERTAIN VETERANS FOR, AND PRIORITIES IN THE FURNISHING OF, HOSPITAL AND NURSING HOME CARE AND MEDICAL SERVICES

SEC. 1105. (a) Subchapter II of chapter 17 is amended by inserting the following new sections:

"§ 612B. Payment in connection with hospital and nursing home care and medical services.

"(a)(1) A veteran who is eligible for care or services under section 610 or 612(f)(1) of this title because of section 610(a)(1)(C) or (2)(C) of this title may not under this subchapter be furnished hospital care, nursing home care (including such care under section 620 of this title), or medical services on an outpatient or ambulatory basis unless the veteran agrees to pay to the United States--

"(A) in the case of each episode of hospital care or nursing home care, for each 60 days of care, an amount equal to the lesser of--

"(i) an amount equal to the amount of the inpatient hospital deductible in effect under section 1813 of the Social Security Act (42 U.S.C. 1395e(b)) at the time such care is furnished; or

"(ii) the cost of furnishing such care, as determined by the Administrator; and

"(B) in the case of each visit in which medical services are furnished on an outpatient or ambulatory basis under section 612(f) of this title, an amount equal to the percentage referred to in paragraph (2) of this subsection of the estimated average cost of an outpatient visit in a Veterans' Administration facility during the fiscal year in which the services are furnished, as determined by the Administrator pursuant to regulations which the Administrator shall prescribe.

"(2) The percentage described in paragraph (1)(B) of this subsection is the percentage of reasonable charges not paid from the Federal Supplementary Medical Insurance Trust Fund pursuant to section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), not taking into account the provisions of the subclauses of such section 1833(a)(1) (42 U.S.C. 1395l(a)(1)).

"(3) In any case in which the Administrator determines, pursuant to regulations which the Administrator shall prescribe, that it is not feasible to request a veteran (or other individual authorized to act on the veteran's behalf) for the veteran's (or such other individual's) agreement pursuant to paragraph (1) of this subsection prior to commencing the furnishing of care or services to the veteran, an obligation to make payments pursuant to such paragraph shall nevertheless be incurred.

"(b) Any moneys collected or received by the Veterans' Administration under this section shall be deposited in the Treasury as miscellaneous receipts.

"(c) For the purpose of subsection (a) of this section:

"(1) The term 'episode of hospital or nursing home care' with respect to a veteran means a period of consecutive days--

"(A) beginning with the first day (not included in a prior episode of such care) on which such veteran is furnished hospital or nursing home care under this subchapter, and

"(B) ending with the close of the first period of 60 consecutive days thereafter on each of which such veteran is not being furnished either hospital care or nursing home care under this subchapter.

"(2) The term '60 days of care' means (A) in the case of a veteran who during an episode of hospital or nursing home care is furnished 60 days or less of care, up to 60 days of hospital or nursing home care (or of any combination thereof), or (B) in the case of a veteran who during an episode of hospital or nursing home care is furnished care for a number of days greater than 60, each period of hospital or nursing home care (or of any combination thereof) of 60 days and, if such number of days is not evenly divisible by 60, the remaining period of care that is less than 60 days.

"§612C. Priorities in furnishing hospital, nursing home, and domiciliary care and medical services.

"(a) The Administrator shall prescribe regulations to ensure that, except in cases involving medical emergencies which pose a serious threat to life or health, priority in furnishing hospital or domiciliary care or medical services under this chapter shall be accorded to veterans in the following order:

"(1) To a veteran for a service-connected disability.

"(2) To a veteran with a service-connected disability rated at 50 percent or more.

"(3) To a veteran who has a service-connected disability rated at less than 50 percent and as compensable in degree (including any veteran being examined to determine the existence or rating of a service-connected disability, for the purposes of such examination).

"(4) To a veteran who, but for the receipt of retirement pay, would be entitled to disability compensation.

"(5) To a veteran who is entitled to disability compensation pursuant to section 351 of this title, or, but for a suspension pursuant to such section, would be entitled to disability compensation, but only if such veteran's continuing eligibility for such care is not limited under a judgment or settlement described in such section.

"(6) To a veteran (A) whose discharge or release from active military, naval, or air service was for a disability incurred or aggravated in line of duty, or (B) with a disability which is service-connected but not compensable in degree.

"(7) To a veteran (A) who is a former prisoner of war, or (B) who, as a result of exposure to a toxic substance or radiation is eligible for care under section 610(a)(1)(B)(iii) of this title, for care as specified in section 610(e) of this title.

"(8) To a veteran of the Spanish-American War, the Mexican border period, or World War I, or who is otherwise being furnished services under section 612(g) of this title.

"(9) To a veteran in receipt of pension under chapter 15 of this title.

"(10) To a veteran who is unable to defray the expenses of necessary care.

"(11) To a veteran being furnished care or services because of section 610(a)(1)(C) or (2)(C) of this title and who is 65 years of age or older.

"(b)(1) The Administrator shall prescribe regulations to ensure that priority in furnishing nursing home care under this chapter shall be accorded in the order set forth in paragraph (2) of this subsection and, within each of the categories specified in such paragraph, in the order specified in subsection (a) of this section.

"(2) The priority order referred to in paragraph (1) of this subsection is as follows:

"(A) Care for a veteran in need of a level or type of nursing home care that (i) is not readily available in a nursing home care facility for which the Administrator may contract under section 620 of this title and which is located in a geographic area where it is reasonable, as determined by the Administrator, for the veteran to be furnished such care, and (ii) is available in a nursing home care facility under the jurisdiction of the Administrator.

"(B) Care for a veteran in need of a level or type of nursing home care that is readily available in such a contract facility in such geographic area.

"(c) The Administrator shall ensure that no guideline, regulation, or other issuance of the Veterans' Administration has the effect of encouraging, directly or indirectly, the furnishing of care or services to a veteran eligible because of section 610(a)(1)(C) or (2)(C) of this title in any fashion not fully consistent with the priorities established by this section.".

(b) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 612A the following new items:

"612B. Payment in connection with hospital and nursing home care and medical services.

"612C. Priorities in furnishing hospital, nursing home, and domiciliary care and medical services.".

DETERMINATION OF A VETERAN'S INABILITY TO DEFRAY NECESSARY EXPENSES

SEC. 1106. Section 622 is amended--

(1) by inserting "(a)" before "For the purposes";

(2) by striking out "610(a)(1)(B)" and inserting in lieu thereof "610(a)(1)(B)(v)";

(3) by striking out "610(b)(2),"; and

(4) by adding at the end the following new subsection:

"(b)(1)(A) Subject to subparagraph (B) of this paragraph and except as provided in paragraph (3) of this subsection, a veteran who does not meet one of the eligibility criteria referred to in subsection (a) shall be determined by the Administrator to be unable to defray necessary expenses for the purpose of the sections of this title referred to in such subsection if the veteran's income (as determined under paragraph (2) of this subsection) during the calendar year preceding the date of the veteran's application for care is not greater than $25,000 (or the applicable greater amount calculated under subparagraph (B) of this paragraph).

"(B)(i) Whenever, after December 1, 1985, maximum annual rates of pension are increased under section 3112(a) of this title, the Administrator shall, effective on the date that the increase in such rates of pension takes effect, increase the dollar amount specified in subparagraph (A) of this paragraph as such amount was in effect immediately prior to the effective date of such increase in such rates of pension, by the same percentage as the percentage by which such rates of pension are increased.

"(ii) In order to avoid hardship, the Administrator, pursuant to regulations which the Administrator shall prescribe, may, in any fiscal year, increase for a specified geographic area the income level established pursuant to subparagraph (A) of this paragraph.

"(2) For the purpose of this subsection, the Administrator shall determine a veteran's income in accordance with section 503 of this title and shall count as income of the veteran any income of a veteran's family member that would be taken into account under section 521(c) of this title.

"(3)(A) The Administrator shall not make a determination that a veteran is unable to defray necessary medical expenses for the purpose of the sections of this title referred to in subsection (a) of this section if the corpus of the estate of the veteran (and of the veteran's spouse and dependent children, if any) is such that, under all the circumstances (including consideration of the annual income of the veteran and of such spouse and dependent children), the Administrator finds it is unreasonable to make such determination.

"(B) In evaluating the corpus of a veteran's estate for the purpose of this paragraph, the Administrator shall consider the same items to be part of the corpus of the veteran's estate as would be so considered under section 522 of this title.".

CONTRACT HOSPITAL CARE AND MEDICAL SERVICES

SEC. 1107. (a) Section 601 is amended--

(1) in paragraph (4)--

(A) in clause (A), by inserting "and" after the semicolon; and

(B) by striking out the semicolon in clause (B) and all that follows through the end of such paragraph and inserting in lieu thereof a period; and

(2) by adding at the end the following new paragraph:

"(9) The term 'non-Veterans' Administration facilities' means facilities other than Veterans' Administration facilities.".

(b)(1) Subchapter I of chapter 17 is amended by adding at the end the following new section:

"§ 603. Contract hospital care and medical services

"When Veterans' Administration facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or of furnishing the care or services required, a requirement or an authority in section 610 or 612 of this title to furnish care or services includes a requirement or authority, as the case may be, to contract with non-Veterans' Administration facilities for the furnishing of hospital care or medical services in order to provide--

"(1) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service;

"(2) medical services for the treatment of any disability of (A) a veteran described in section 612(a)(1)(B) of this title, (B) a veteran described in clause (1)(B) of the first sentence, or in the third sentence (but only to the extent authorized therein), of section 612(f) of this title, or (C) a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in Veterans' Administration facilities;

"(3) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Veterans' Administration facility until such time following the furnishing of care in the non-Veterans'Administration facility as the veteran can be safely transferred to a Veterans' Administration facility;

"(4) hospital care for women veterans;

"(5) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the forty-eight contiguous States, except that the annually determined hospital patient load and incidence of the provision of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and private facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by the Veterans' Administration within the forty-eight contiguous States, but the authority of the Administrator under this subclause (except with respect to Alaska and Hawaii) shall expire on October 31, 1985, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico and to the Virgin Islands of the restrictions in this subclause with respect to hospital patient loads and incidence of provision of medical services; or

"(6) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent Veterans' Administration outpatient clinics to obviate the need for hospital admission.

In the case of any veteran for whom the Administrator contracts to provide care or services in a private facility pursuant to a provision of this section, the Administrator shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.".

(2) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 602 the following new item:

"603. Contract hospital care and medical services.".

IMPLEMENTATION REPORT

SEC. 1108. Not later than December 1, 1985, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on procedures that the Administrator has established for implementation of section 612B of title 38, United States Code, as added by section 1105(a) of this Act. Such report shall contain information with respect to the guidelines and processes for (1) implementation of income criteria established by and under the amendments made by this Part for Veterans' Administration health-care eligibility, and (2) for the collection of payments required by the amendments made by this Part.

EFFECTIVE DATE

SEC. 1109. (a) Except as provided in subsection (b), the amendments made by this part shall apply to hospital care, nursing home care, domiciliary care, and medical services furnished on or after November 1, 1985.

(b)(1) The provisions of sections 610 and 622 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital and nursing home care furnished on or after November 1, 1985, to veterans who were furnished such care on October 31, 1985, but only to the extent that such care is furnished with respect to the same period of care for which it was furnished on October 31, 1985, as determined by the Administrator pursuant to regulations which the Administrator shall prescribe.

(2) During the month of November 1985, the Administrator may,

in order to continue a course of treatment begun prior to November 1, 1985, furnish medical services to a veteran on an ambulatory or outpatient basis without regard to the amendments made by this Part.

(3) For the purpose of this subsection--

(A) the term "period of care" means a period of consecutive days--

(i) beginning with the first day on which a veteran is furnished hospital or nursing home care, and

(ii) ending with the veteran's discharge from the hospital or nursing home facility, as the case may be;

(B) the terms "hospital care", "medical services", and "domiciliary care" have the meanings given those terms in paragraphs (5), (6), and (8), respectively, of section 601 of title 38, United States Code; and

(C) the terms "veteran" and "nursing home care" have the meanings given those terms in paragraphs (2) and (28), respectively, of section 101 of such title.

PART B -- RECOVERY OF THE COST OF CERTAIN HEALTH CARE AND SERVICES FURNISHED BY THE VETERANS' ADMINISTRATION

SEC. 1111. (a) Section 629 of title 38, United States Code, is amended to read as follows:

"§629. Recovery by the United States of the cost of certain care and services

"(a)(1) Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Administrator) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

"(2) Paragraph (1) of this subsection applies to a non-service-connected disability--

"(A) that is incurred incident to the veteran's employment and that is covered under a workers' compensation law or plan that provides for payment for the cost of health care and services provided to the veteran by reason of the disability;

"(B) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

"(C) that is incurred as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime; or

"(D) that is incurred by a veteran who does not have a service-connected disability and who is entitled to care (or payment of the expenses of care) under a health-plan contract.

"(3) In the case of a health-plan contract that contains a requirement for a deductible or copayment by the veteran--

"(A) the veteran's not having paid such deductible or copayment with respect to care or services furnished under this chapter shall not preclude recovery or collection under this section; and

"(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

"(b)(1) The United States shall, as to the right provided in subsection (a) of this section, be subrogated to any right or claim that the veteran (or the veteran's personal representative, successor, dependents, or survivors) may have against a third party.

"(2)(A) In order to enforce any right or claim to which the United States is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran (or the veteran's personal representative, successor, dependents, or survivors) against a third party.

"(B) If--

"(i) no such action or proceeding is begun within 180 days after the first day on which care or services for which recovery is sought were furnished to the veteran by the Administrator under this chapter, and

"(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute legal proceedings,

the United States may, after 60 days have lapsed from the mailing of such notice, institute and prosecute legal proceedings against the third party.

"(c)(1) The Administrator may compromise, settle, or waive any claim which the United States has under this section.

"(2)(A) The Administrator, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining the reasonable cost of care or services under subsection (a)(1) of this section. Any determination of such cost shall be made in accordance with such regulations.

"(B) Such regulations shall provide that in no event may the reasonable cost of care or services sought to be recovered or collected from a third-party liable under a health-plan contract exceed an amount equal to the prevailing rate that such third party can demonstrate to the satisfaction of the Administrator it would pay for the care or services under comparable health-care contracts with facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

"(C) Not later than 45 days after the date on which the Administrator prescribes such regulations or any amendment to such regulations, the Comptroller General shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the Comptroller General's comments on and recommendations regarding such regulations or amendment.

"(d) Any contract or agreement into which the Administrator enters with a person under section 3718 of title 31 for collection services to recover indebtedness owed the United States under this section shall provide, with respect to such services, that such person is subject to sections 3301 and 4132 of this title.

"(e) A veteran eligible for care or services under this chapter (1) may not be denied such care or services by reason of this section, and (2) shall not be required by reason of this section to make any copayment or deductible payments in order to receive such care.

"(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 611(b) of this title.

"(g) Any moneys collected or recovered on behalf of the United States under this section shall be deposited into the Treasury as miscellaneous receipts.

"(h) Medical records of a veteran who is a beneficiary of a health-plan contract under which recovery or collection is sought under this section from the third party concerned for the cost of the care or services furnished to such veteran shall be made available, under such conditions to protect the confidentiality of such records as the Administrator shall prescribe in regulations, for inspection and review by representatives of such third party for the sole purpose of permitting the plan to verify that the care or services for which recovery or collection is sought were furnished and that the provision of such care or services meets criteria generally applicable under the contract.

"(i) For purposes of this section--

"(1) The term 'health-plan contract' means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

"(2) The term 'payment' includes reimbursement and indemnification.

"(3) The term 'third party' means a State or political subdivision of a State, an employer, an employer's insurance carrier, automobile accident reparations insurance carrier, or a person obligated to provide, or to pay the expenses of, health services under a health-plan contract, except that such term does not include an insurance program described in section 1811 of the Social Security Act or established by section 1831 of such Act or a

State plan for medical assistance approved under title XIX of such Act.".

(b)(1)(A) Except as provided in subparagraph (B), the amendment made by subsection (a) shall apply to care and services provided on or after the date of the enactment of this Act.

(B)(i) The amendment made by subsection (a) shall not apply so as to nullify any provision of a health-plan contract (as defined in subsection (i) of section 629 of title 38, United States Code, as amended by subsection (a)) that was entered into before such date and is not modified or renewed on or after such date.

(ii) In the case of a health-plan contract (as so defined) that was entered into before such date but which is modified or renewed on or after such date, the amendment made by subsection (a) shall apply with respect to such plan as of the day after the date that it is so modified or renewed and with respect to care and services provided after such date of modification or renewal.

(2) For purposes of paragraph (1), the term "modified" includes any change in premium or coverage.

(c)(1) Not later than 6 months after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the process for and results (including costs of administration and the amount of receipts and collections) of the implementation of the amendment made by this section.

(2) Not later than February 1, 1987, and February 1 of each year thereafter, the Administrator shall submit to such Committees a report

updating the information in the most recent report under this subsection and providing information on the process and results of such implementation with respect to the most recent full fiscal year preceding the date on which the report is required to be submited under this paragraph.

PART C -- LIMITATION ON INCREASE IN RATES OF VETERANS' ADMINISTRATION COMPENSATION

SEC. 1121. No legislation shall be enacted that would (1) effective in fiscal year 1986, increase one or more rates of the benefits under chapter 11 or 13 of title 38, United States Code, by a percentage greater than 3.7 percent, or (2) cause the total costs of legislation increasing such rates in fiscal year 1986 to exceed $311,000,000 in budget authority or $280,000,000 in outlays in fiscal year 1986.

TITLE XI: BUDGET RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON VETERANS' AFFAIRS

INTRODUCTION

The Committee on Veterans' Affairs has been instructed by the Congress in section 2(1) of Senate Concurrent Resolution 32, the First Concurrent Resolution on the Budget for Fiscal Year 1986, to submit, not later than September 27, 1985, to the Committee on the Budget, recommendations for changes in laws within the jurisdiction of the Committee on Veterans' Affairs, including those which provide spending authority described in section 401(c)(2)(C) of the Congressional Budget Act of 1974, in order to reduce budget authority by $300,000,000 and outlays by $300,000,000 in fiscal year 1986; to reduce budget authority by $400,000,000 and outlays by $400,000,000 in fiscal year 1987; and to reduce budget authority by $450,000,000 and outlays by $450,000,000 in fiscal year 1988.

The Committee legislation would achieve savings during fiscal years 1986-88 as required by section 2(1) of S. Con. Res. 32.

In order to prepare for the reconciliation process this year, this Committee held hearings on May 7 and June 20, 1985, for the purpose of receiving testimony on several of the Administration's legislative proposals, including a means test for Veterans' Administration health-care eligibility and reimbursement from health insurers.

After due consideration, on September 26, 1985, this Committee met in open markup session and voted, 9 to 3, to recommend and to submit to the Budget Committee reconciliation legislation including: in Part A, an income eligibility criterion which is substantially different from the Administration's means-test proposal; in Part B, authorization for reimbursement from health insurers which is derived from the Administration's proposal; and in Part C, a limitation on the FY 1986 cost-of-living adjustment rates for the VA compensation and dependency and indemnity compensation (DIC) programs.

On September 26, 1985, this Committee met in open markup session and voted, 9-3, to report the reconciliation legislation favorably.

TITLE XI - VETERANS' PROGRAMS

DISCUSSION

The Committee, after careful consideration of all the testimony presented during the May 7 and June 20, 1985, hearings on the Administration's means test and third-party reimbursement proposals, has concluded that legislation to (1) revise certain VA health-care eligibility criteria and to provide for certain veterans with substantial incomes to make modest payments for VA care furnished for non-service-connected disabled veterans, in the way set forth in Part A, (2) authorize the United States to recover certain reasonable costs of care and services furnished through VA facilities or non-VA facilities at VA expense for veterans with no service-connected disablilities who are covered under health-plan contracts, and (3) restrict a disability compensation/DIC COLA rate increase to 3.7 percent estimated as the forthcoming Social Security benefit COLA is the best available means for the Commitee to comply with the reconciliation instructions to it in section 2 (*l*) of the First Concurrent Resolution on the Budget for Fiscal Year 1986 (S. Con. Res. 32).

The Committee notes generally that further explanation and expression of Committee views is found in the section-by-section analysis of the Committee legislation later in the report.

PART A: ENTITLEMENTS AND ELIGIBILITIES FOR HEALTH CARE FROM THE VETERANS' ADMINISTRATION

Part A of the Committee legislation would clarify eligibility categories and priorities for health care provided for or furnished by the Veterans' Administration, would establish expanded eligibility for such health care for certain veterans with service-connected disabilities, and establish an income eligibility criterion for non-service-connected veterans.

Hospital Care

This legislation would create three categories of eligibility for hospital care. In the first category the Administrator would be required to furnish hospital care determined to be reasonably necessary to veterans for their service-connected disabilities and for any disability of veterans who have service-connected disabilities rated at 50 percent or more. This care would be required to be furnished through VA facilities or non-VA facilities to the extent authorized. The Committee notes that this eligibility would not in anyway alter the authority of the Administrator with respect to incarcerated veterans.

The second category would maintain the Administrator's authority under current law to furnish reasonably necessary hospital care to veterans with a service-connected disability rated at less than 50 percent (including zero-percent rated veterans); veterans who, but for the receipt of retired pay, would be entitled to disability compensation; veterans who, but for a suspension in disability compensation paid for a disability incurred as a VA patient or as a participant in a VA vocational rehabilitation program, would be entitled to such compensation; veterans who were discharged from service for a disability incurred or aggravated during service; former prisoners of war; Vietnam veterans exposed to certain toxic substances and veterans exposed to ionizing radiation from a nuclear blast; Spanish-American War, Mexican border period, World War I, or permanently housebound veterans; and veterans unable to defray the cost of necessary care.

Under the third category, the Administrator would have the authority to furnish within otherwise available space and resources, reasonably necessary hospital care for disabilities of veterans not covered by categories one or two, whose annual family income exceeds $25,000 and who agree to make certain payments to the United States in connection with such care. In determining the incomes of veterans for the purpose of this category, the Administrator would be required to use the same methods and criteria used to determine annual income (including taking into account family income) for the purposes of VA pension eligibility. Further, the Administrator would be given authority to prescribe regulations defining the circumstances under which a non-service-connected veteran having an annual income or estate above a certain level would be ineligible for VA care.

The Committee, after careful consideration of testimony presented at hearings on May 7 and June 20, 1985, is recommending the new entitlement/eligibility criteria and the income eligibility criterion to ensure (1) that service-connected veterans, whom the VA health-care system was primarily designed to serve, are furnished VA health care; (2) that all other veterans eligible under current law, including those who are unable to defray the cost of needed care, may continue to receive reasonably necessary care from the VA; and that veterans with family incomes above the $25,000 income eligibility criterion would not be barred from VA care but could receive care and services if capacity and resources are available and if they meet modest payment requirements.

With reference to determining whether a veteran meets the new income eligibility criterion, the Committee notes that it does not support a "spend down" provision and that under the Committee legislation no veteran over that income level would be required to "spend down". The Committee has structured this new criterion to require veterans who can defray the cost of care to pay the VA for a modest portion of the cost of the care they receive.

With reference to the third category of veterans discussed above -- those with incomes over $25,000 -- the Committee notes that, by virtue of the new eligibility provision, a veteran with income over $25,000 who is 65 year of age or older would still be eligible for VA care (on a space-available basis) upon agreement to pay a modest payment and would be afforded priority for care ahead of a veteran with income over $25,000 who is under age 65. There would be no eligibility change as to a veteran over age 65 with annual income of $25,000 or less; the veteran, however, could be required to demonstrate the level of his or her family income. The Committee notes further with respect to this discretionary category of eligibility that it does not intend that beneficiary travel be paid or that, absent extraordinary circumstances, appliances as described in the definition of "medical services" in title 38 be provided in connection with the care of these veterans. The eligibility of this category of veterans for care "to obviate the need of. . . hospital admission" would be the lowest order of priority and would be strictly on a space-and-resource-available basis. The Committee also notes its intent that the eligibility of this category of veterans on a space-and-resources-available basis should not be taken into account for purpose of planning, budgeting, or appropriations for the VA health-care system.

The Committee notes its intention that every veteran applying for care on the basis of inability to defray expenses should sign an agreement to pay the VA the payments provided for veterans with annual incomes over $25,000 in the event it is determined that the veteran's annual income is in excess of that amount and the veteran has no other eligibility for care.

The Committee notes that, although a veteran with income above $25,000 would generally be eligible for care or services only upon the veteran (or someone authorized to act for him or her) entering into a written agreement to pay a modest amount for those services before they are provided, the VA has full authority under current section 611(b) to furnish hospital care and medical services in emergency cases and then to charge appropriately for such care and this emergency authority would be applicable in the case of a veteran in this category of eligibility who is unable to execute such an agreement prior to the commencement of care.

With reference to the authority to determine a veteran's income, the Committee expects that the Administrator would generally, as has been done for purposes of the pension program, disregard the value of the veteran's primary residence as well as a vehicle used for transportation purposes.

Nursing Home Care

The Committee legislation would also provide for an entitlement to reasonably necessary nursing home care (direct VA or by contract with a community facility) for a service-connected disability. This change is consistent with the changes in eligibility for hospital and ambulatory or outpatient care. The Administrator would continue to have authority to furnish nursing home care determined to be reasonably necessary for veterans for the care of non-service-connected disabilities.

Domiciliary Care

Under the Committee legislation, the Administrator would have the authority to furnish reasonably necessary domiciliary care to veterans who are determined by the Administrator to be incapacitated from earning a living and to have no adequate means of support. This standard based on a veteran's resources is the same as exists in current law for determining service-connected veterans' eligibility for domiciliary care and is the standard generally applied under current VA regulation (38 C.F.R. 17.47(c)(3) and (d)(3)).

Ambulatory or Outpatient Medical Services

Under the Committee legislation the Administrator would be required to furnish reasonably necessary ambulatory or outpatient medical services and home health services for the treatment of service-connected disabilities and for any disability of veterans who have service-connected disabilities rated at 50 percent or more. The Administrator would continue to have discretionary authority to provide ambulatory or outpatient medical services to (1) veterans eligible for hospital care in order to prepare for or obviate the need for hospital care or to provide post-hospital care and (2) generally to veterans who are former prisoners of war and to veterans of the Mexican border period or of World War I or who are in receipt of (or, but for receipt of retired pay, would be in receipt of) increased pension or additional compensation or allowance based on the need of regular aid and attendance or being permanently housebound.

Amounts of Payments

The Committee has given careful consideration to the establishment of the new income eligibility criterion and to the treatment of those veterans who, under this criterion, are determined able to defray the cost of necessary care. The Committee bill would establish a new requirement of payment in connection with hospital, nursing home, and medical services which is generally comparable to the payment structure for Medicare under the Social Security Act. However, the payments required under the Committee provisions would be substantially less than payment under Medicare for episodes of inpatient care beyond 60 days. Under the Committee bill, for each period of hospital or nursing home care up to 60 days, such a veteran would be required to pay a deductible equal to either the amount of the hospital deductible required under Medicare (estimated to rise to approximately $476 in fiscal year 1986) or the cost of the care, whichever is the lesser. In the case of ambulatory or outpatient care, such a veteran would be required to pay an amount equal to 20 percent -- the percentage that Medicare generally does not pay for such care -- of the average cost of an outpatient visit in a Veterans' Administration facility as determined by the Administrator pursuant to regulations.

The Committee notes that under these provisions, a veteran who has received 60 days of hospital or nursing home care would not be liable for any more than the actual cost of the care furnished during any subsequent period. For example, if a veteran with more than $25,000 income received care in a VA nursing home from the VA for 62 consecutive days, the veteran would not have to pay a second time the Medicare-hospital-equivalent deductible, but rather would pay for the 61st and 62nd day of VA nursing home care (currently costed at approximately $112 per day) in addition to the deductible for the first 60 days of care.

The Committee notes that any amount collected from a veteran for hospital care or medical services by virtue of these provisions would reduce the amount of reimbursement that the VA could collect by virtue of the amendments proposed to made by Part B of the Committee legislation, from third-party health-care contractors.

Priorities

The Committee legislation would also require the Administrator to establish statutory priorities for furnishing hospital, domiciliary, and nursing home care and medical services and to prescribe regulations to ensure that care and services are provided in that order. Except in the cases of a medical emergency, the priorities for hospital, domiciliary, and ambulatory or outpatient care would be the following: (1) veterans who require treatment for service-connected disabilities, (2) veterans with service-connected disabilities for any disability rated at 50 percent or more, (3) veterans with compensable service-connected disabilities rated at less than 50 percent, (4) veterans who, but for the receipt of retired pay, would be entitled to disability compensation, (5) veterans who, but for a suspension in compensation paid for a disability incurred as a VA patient or as a participant in a VA vocational rehabilitation program, would be entitled to disability compensation, (6) veterans (A) who were discharged from service for a disability incurred or aggravated during service or (B) with noncompensable service-connected disabilities, (7) (A) former prisoners of war and (B) Vietnam veterans exposed to certain toxic substances or veterans exposed to ionizing radiation from nuclear blasts, (8) Spanish-American War veterans, Mexican border period veterans, or World War I veterans, or veterans receiving VA pension who are permanently housebound or in need of aid and attendance, (9) other veterans in receipt of needs-based VA pension, (10) other veterans who are unable to defray the cost of health-care, and (11) veterans who have incomes above $25,000, who are 65 year old, and who are eligible for hospital and nursing home care by virtue of agreeing to make payments to the VA.

The Committee legislation would require the Administrator to prescribe regulations to establish priorities for nursing home care taking into account the level of need for care. Under these regulations, veterans who, because of the nature of their disability, are in need of a level or type of nursing home care that is not readily available in a contract facility in an appropriate geographic area but which is available in a VA facility would receive priority for admission to a VA-run nursing home over a veteran not in need of such a level of care. Veterans in need of a level or type of nursing home care that is readily available in a contract facility in an appropriate geographic area would receive the second basic priority. Within each of these two categories of veterans, the general priority order (described above) would apply.

Income Measurement

In reaching a determination as to an appropriate level of income above which veterans would be considered as able to defray the cost of needed care, the Committee carefully evaluated the testimony and information received during its deliberation on this issue. Based upon its review, the Committee believes that an across-the-board $25,000 income threshold as included in the Committee bill, is more equitable than the level based on a multiple of twice the applicable VA pension income standard, set forth in the original Administration proposal, which would produce an approximately $15,000 income level for a veteran with one dependent. Under the Committee bill a non-service-connected veteran with family income above $25,000 would be required to pay a modest amount for VA hospital, nursing home, or ambulatory or outpatient care received. The veteran's income would be determined (upon the first application for care each year) based on the veteran's family income for the calendar year immediately preceding the veteran's application for care (rather than being required to be determined upon each application based on the 12 months immediately preceding the application for care). In the event that an annual cost-of-living adjustment (COLA) were provided for VA pension, the Administrator would be required to raise the income threshold by the same percentage as the pension COLA.

During the course of the Committee's May 7 and June 20 hearings on various Administration proposals relating to VA health-care eligibility, a number of witnesses expressed concerns over the wide variations that exist in income levels and medical care costs throughout the country. Accordingly, under the Committee legislation, the Administrator would be provided with the discretionary authority to increase, in any fiscal year, the income level for a specified geographic area, in order to avoid substantial hardship on the part of veterans requiring care.

Reports

The Committee legislation would require the Administrator to submit to the Veterans' Affairs Committees, not later than December 1, 1985, a report on the implementation of the income eligibility criterion and other criteria established by or under this legislation and the mechanism for collecting payments from veterans who are able to defray the cost of necessary hospital care, nursing home care, or medical services. The Committee directs the Administrator to take action to ensure the prompt establishment of guidelines for payment and debt-collection procedures in order to implement the provision for payments. These guidelines should include instructions to ensure that in the case of a veteran who is furnished care under the first or second basic eligibility categories (discussed above) but later is determined eligible for care only under the third eligibility category, the veteran would be billed for the care as though furnished under the third category.

Effective Date

The amendments made by the Committee bill would apply to care provided after November 1, 1985, except in cases where the veteran was being furnished hospital or nursing home care on October 31, 1985. These veterans would be unaffected until they are discharged from such care. During the month of November 1985, the Administrator would be authorized to continue a course of ambulatory or outpatient treatment begun prior to November 1, without regard to the Committee recommended legislation.

Savings

The Congressional Budget Office has estimated that the provisions in part A of the Committee legislation would generate net reconciliation savings of $50 million in budget authority and $47 million in outlays in FY 1986, $92 million in budget authority and $[illegible] million in outlays in FY 1987, and $101 million in budget authority and $95 million in outlays in FY 1988.

PART B: RECOVERY OF THE COST OF CERTAIN HEALTH CARE AND SERVICES FURNISHED BY THE VETERANS' ADMINISTRATION

Part B of the Committee legislation would revise current section 629 of title 38, United States Code, to allow the United States to recover from a third party the cost of medical care and services furnished to certain veterans through VA facilities or non-VA facilities at VA expense. Recovery under revised section 629 of title 38 would be authorized only for non-service-connected veterans insured under a health-plan contract and only to the extent that the veteran or the provider would be eligible for payment by the third party if the care or services had not been provided by a department or agency of the United States.

As in current law, revised section 629 of title 38 would authorize the United States to recover or collect the reasonable costs of care and services furnished under chapter 17 of title 38 for the treatment of non-service-connected disabilities which are covered under a workers' compensation law, any State law concerning no-fault automobile insurance, or any State or local program of compensation for victims of a crime of personal violence.

Currently, most health insurance plans and contracts contain exclusionary clauses which bar reimbursement to the United States for care provided by the VA because the veteran is not charged for the care and services furnished. The Committee legislation authorizing third-party reimbursement despite such exclusionary clauses is derived, with modifications, from the draft bill transmitted by the Administration on May 7, 1985, and would place the VA in a status comparable to that of private health-care providers with respect to their ability to recover from health insurers.

Constitutionality of Prospective Application

Representatives of private health insurers who testified before the Veterans' Affairs Committee on June 20, 1985, expressed strong concern over the constitutionality of the recovery legislation under consideration. Revised section 629 would apply only to care and services provided on or after the date of enactment and would not affect or nullify any provision of an existing health-plan contract which is entered into prior to the enactment date of this legislation, unless the contract is modified or renewed after the enactment date. For care and services provided after the date of such a renewal or modification, revised section 629 would take effect on the day following any such modification or renewal. "Modification" is defined as including any change of premium or coverage under a health-plan contract. These prospective aspects of the provision for health-plan contract recoveries are designed to address the concerns expressed by the insurers. The legal opinions this Committee has received from the Department of Justice and the General Counsel of the Veterans' Administration conclude that legislation to authorize prospective recovery from third-party health insurers would be constitutional.

New Provisions

The Committee legislation would add to title 38 several new corollary provisions necessary to implement the expansion of section 629.

Deductible and copayment contract provisions: If a health-plan contract between a veteran and a third party provides for a deductible or a copayment, the VA could not require any veteran eligible for care or services to make any such deductible payment or copayment to the VA in order to receive VA care. However, the Committee notes that the fact that the veteran does not pay the deductible or copayment required under a health-care contract for care or services furnished by the VA would not bar the recovery or collection from a third party by the United States for the reasonable cost of the VA-furnished care in excess of the amount of the deductible or copayment.

Collection of payments: The Administrator of Veterans' Affairs would be authorized to compromise, settle, or waive any claim of the United States in accordance with the provisions of pertinent Federal law. Funds collected or recovered by the United States would be deposited in the Treasury as miscellaneous receipts and would not be used to reduce or to offset annual appropriations for the Veterans' Administration health-care system.

Determining the amount of payments: The Administrator would be required under the Committee legislation, after consultation with the Comptroller General of the United States, to prescribe regulations for determining the "reasonable cost" of care and services provided by this section. The Comptroller General would be required to submit to the Veterans' Affairs Committees written comments on the regulations the VA adopts. The legislation would also provide that the amount which may be recovered or collected under a health-plan contract from a third party could not exceed the amount that the third-party payer demonstrates to the satisfaction of the Administrator is its prevailing rate of reimbursement, under comparable health-plan contracts, to non-federal health-care facilities in the same geographical area. This provision would provide a safeguard in response to the private health insurers' concerns about the effectiveness of cost containment measures within the Veterans' Administration. Also, the Committee legislation would permit a third-party payer, subject to confidentiality protections to be prescribed by regulations, to inspect and to review the medical records of a veteran beneficiary to verify that the care or services upon which reimbursement is based were furnished and that they were provided in accordance with the criteria of the health-plan contract.

Reports to Congress: The Committee believes that the changes that would be made by this health-insurance recovery legislation might result in major policy changes within the VA Department of Medicine and Surgery. Therefore, the Committee legislation would require the Administrator to submit reports to Congress within six months after enactment, and by February 1, 1987, and annually thereafter, on the implementation process and the results of the part B legislation, including administrative costs incurred and the amount of receipts and collections from third parties. The Committee intends that the initial report provide detailed descriptions of the implementation process and results. Annual reports thereafter would update the information included in the initial report.

Current Law Provisions Retained

Finally, revised section 629 retains many provisions of current law. These include: subrogation, intervention and joinder rights of the United States against a third party; the right of the United States to institute and to prosecute legal proceedings for recovery or collection from a third party; a prohibition against the denial of care or services by reason of this section to eligible veterans; and a provision protecting the right of the United States to recover or to collect from third parties under section 629 and section 611(b) of title 38 (relating to VA care furnished in emergency cases) from being defeated by any state or local law or any provision of a contract or other agreement.

Emergency Care

The Committee notes that there may be situations, after enactment of the income eligibility criterion in part A of the Committee legislation and the new third-party reimbursement legislation, wherein a veteran who would be considered able to defray the cost of his or her care under the new income eligibility criterion is furnished VA care or services in an emergency, even though under non-emergency circumstances the veteran would have been required, prior to the commencement of care, to sign a written agreement to make payment to the United States for the care. In these situations, the Committee intends that the treatment be provided if a medical necessity exists. However, the veteran would be required, in accordance with part A of this legislation, to make a limited payment to the VA. Also, if such a veteran is covered by a health-plan contract, the United States would be authorized to obtain reimbursement from the third party for the reasonable cost of care in excess of the amount charged the veteran. Whether and to what extent the veteran, in turn, would be entitled to have the third party pay the amount charged would be determined by the terms and conditions of the health-care contract.

Compliance with Basic Contract Terms and Conditions

With respect to part B generally, the Committee notes that the language providing for the right of recovery of the cost of care "to the extent" that the veteran or a non-Federal provider would be eligible to receive payment generally leaves the Federal Government's right to recover contingent upon compliance with the terms and conditions of the law, contract, or other arrangement under which the veteran would be eligible for payment by the third party. Only where the Committee legislation specifically overrides such terms or conditions -- for example, the provision in the legislation nullifying preclusions of liability for VA care or the provisions providing for recovery despite a deductible or copayment requirement not being met -- would such requirements be avoided. Thus, contract requirements conditioning the third-party's liability (such as for pre-hospitalization screening, second opinions prior to surgery, or other specified utilization review procedures) would apply. Likewise, provisions imposing general limitations on the third-party's liability -- such as contract clauses placing specific dollar limits on payments for certain procedures or limiting a carrier's liability to a percentage of certain charges -- would apply. The Committee intends the VA to adopt procedures necessary to comply with such contract requirements in order to make maximum collections under these health-plan contracts. Further, the Committee notes that any payment collected from a veteran for hospital care or medical services by virtue of new section 612B proposed to be added by part A of this Committee legislation would reduce the amount of reimbursement that the VA could collect from third-party health-care contractors.

Savings

The Congressional Budget Office has estimated that the third-party reimbursement legislation would generate net budget authority and outlay reconciliation savings of $203 million for FY 1986, $354 million for FY 1987, and $403 million for FY 1988.

PART C: LIMITATION ON VA COMPENSATION
COST-OF-LIVING ADJUSTMENT LEGISLATION

Part C of the Committee legislation would limit any fiscal year 1986 increase in rates for disability compensation, additional compensation for dependents, the clothing allowance paid to certain service-connected disabled veterans, dependency and indemnity compensation (DIC) paid to certain surviving spouses and children of deceased veterans or servicemembers, and supplemental DIC paid to the surviving children of certain deceased veterans.

This provision would require that the cost of legislation that would increase those rates be limited to no more than $311,000,000 in budget authority or $280,000,000 in outlays in fiscal year 1986, and that none of the rates be increased during fiscal year 1986 by more than 3.7 percent.

The First Concurrent Resolution on the Budget for FY 1986 assumed a 4.1-percent rate adjustment due to projected increases in the cost of living. This figure was based on the Administration's February 1985 estimate of the percentage by which Social Security and VA pension benefits will be automatically increased under current law effective December 1, 1985. The Congressional Budget Office's most current estimate is 3.7 percent, and the Administration's latest estimate (in its August 1985 mid-session review) is 3.6 percent. In view of these more recent estimates, the Committee believes that even with the compensation/DIC increase limited to 3.7-percent, the Committee would be able to propose legislation providing compensation and DIC beneficiaries with the same increase as that projected for Social Security and VA pension beneficiaries. This would continue the Committee's longstanding policy that cost-of-living adjustments for disability compensation and DIC should be at the same percentage as the indexed Social Security/VA pension increases, while, in this reconciliation proposal, still achieving the additional savings necessary (when coupled with those estimated to be achieved by parts A and B of the Committee legislation) to meet the reconciliation savings mandated under the First Concurrent Resolution on the Budget for FY 1986.

Savings

An increase of 3.7 percent rather than 4.1 percent would result in budget authority savings of $34 million and outlay savings of $30 million in fiscal year 1986, $40 million savings in both budget authority and outlays in FY 1987, and $39 million savings in both budget authority and outlays in FY 1988.

COST ESTIMATE

On September 27, 1985, the Congressional Budget Office (CBO) provided the Committee with a cost estimate of the Committee legislation. The Committee adopts the cost estimate of the Congressional Budget Office, however, the Committee understands that CBO estimated that administrative costs for the implementation and operation of part A of the Committee legislation would be $22 million during fiscal year 1986, whereas the Veterans' Administration has estimated that the fiscal year 1986 administrative costs of part A would be $7.9 million. The Committee believes that the estimate of the Veterans' Administration is more accurate. Thus, the Committee assumes that the fiscal year 1986 administrative costs for part A of the Committee legislation will be approximately $10 million, and believes that the overall Function 700 savings reflected in the CBO cost estimate for fiscal year 1986 should be increased accordingly by $12 million in both budget authority and outlays. This increased savings would result in a total of $299 million savings in budget authority and $292 million savings in outlays for the Veterans' Administration for fiscal year 1986.

The Congressional Budget Office estimate is as follows:

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Rudolph G. Penner
Director

September 27, 1985

Honorable Frank H. Murkowski
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the attached cost estimate for the provisions reducing spending in programs within the jurisdiction of the Senate Committee on Veterans' Affairs, as ordered transmitted to the Senate Committee on the Budget by the Senate Committee on Veterans' Affairs, September 26, 1985.

The estimates included in the attached report represent the 1985-1990 effects on the federal budget and on the budget resolution baseline of the Committee's legislative proposals. CBO understands that the staff of the Committee on the Budget will be responsible for interpreting how the savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

Rudy Penner

Rudolph G. Penner

cc: Honorable Alan Cranston
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 27, 1985

1. BILL TITLE:

Provisions reducing spending in programs within the jurisdiction of the Senate Committee on Veterans' Affairs.

2. BILL STATUS:

As ordered reported by the Senate Committee on Veterans' Affairs, September 26, 1985.

3. BILL PURPOSE:

To reduce expenditures authorized by the Senate Committee on Veterans' Affairs in response to budgetary requirements established for that Committee by the First Concurrent Resolution on the Budget for fiscal year 1986.

4. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(by fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Function 700					
Budget Authority	-289	-489	-547	-602	-662
Outlays	-285	-489	-547	-602	-662
Function 570					
Budget Authority	2	3	4	3	4
Outlays	5	9	10	11	13
Net Budgetary Impact					
Budget Authority	-287	-486	-543	-599	-658
Outlays	-280	-480	-537	-591	-649

The effects of this bill would fall in budget functions 700 and 570.

Basis of Estimate:

This estimate assumes an enactment date of October 1, 1985. If enactment of the bill should occur after this date, the budgetary impact in fiscal year 1986 could be significantly different from that shown above.

The following cost analysis only addresses those sections of the bill that could be expected to have a significant budgetary impact.

Part A. Entitlements and Eligibilities for Health Care from the Veterans Administration.

This section would establish an income test that would be applied to certain veterans seeking health care from the VA. All veterans with family incomes below $25,000 (the income eligibility criterion) and certain categories of veterans without regard to income would be considered eligible for free hospital, ambulatory, and nursing home care in VA facilities. Veterans with incomes above this amount would be provided medical care if space is available but would be required to pay coinsurance, equal to the deductible charged by Medicare, for every 60 days of inpatient care that they receive. For outpatient care, veterans with incomes above the income eligibility criterion would be required to pay coinsurance, equal to 20 percent of the average VA cost of an outpatient visit, for every outpatient visit.

(by fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Function 700					
Budget Authority	-52	-95	-105	-115	-125
Outlays	-52	-95	-105	-115	-125
Function 570					
Budget Authority	2	3	4	3	4
Outlays	5	9	10	11	13
Net Budgetary Impact					
Budget Authority	-50	-92	-101	-112	-121
Outlays	-47	-86	-95	-104	-112

This estimate was derived through the use of a computer model that is based on a projection of total discharges expected from all VA hospitals in future years under current law. This projection was derived by multiplying age-specific projections of the veteran population by estimated use rates. (See Congressional Budget Office, Veterans Administration Health Care: Planning for Future Years, April 1984.) The model reduces the anticipated number of discharges by the percent estimated in each year who would qualify for free health care under the bill and, thus, would not be subject to the income test.

Of the population subject to the income test, it was assumed that 6.5 percent of those who would be required to pay coinsurance would chose to receive their care elsewhere. This number of discharges was multiplied by the projected average cost per patient treated to calculate the savings from veterans choosing alternative care. The model then calculates the number of veterans who would exceed the income criterion based on income distribution data from the 1979 National Survey of Veterans conducted by the VA. The number of veterans paying coinsurance was distributed by 60-day increments of length of stay, based on an actual distribution of 1984 VA hospital discharges by length of stay. The number of veterans in each 60-day increment was then multiplied by the projected Medicare deductible amount and the expected number of payments to determine the estimated amount of coinsurance collections. A similar process was used to estimate the copayment collections and the savings from those leaving the outpatient care system.

Based on data from the Survey of Aging Veterans (Lou Harris and Associates, 1983), it was estimated that in 1986, 23 percent of the veterans who would choose to obtain their health care outside of the VA rather than pay the required coinsurance would have Medicare Hospital Insurance and 21 percent would have Supplementary Medical Insurance. The shifting of these few cases from VA hospitals to Medicare-covered stays in private or community hospitals would result in the small offsetting cost in budget function 570 shown above.

This estimate assumes that the interview and paperwork required to evaluate a prospective patient without statutory eligibility for free care would take one hour, on the average, and would be performed by a GS-7 employee. The assumed grade level is based on information from the VA. An average cost of billing and collecting inpatient coinsurance payments of $30 per bill was used, based on data from the General Accounting Office (GAO) study, Legislation to Authorize VA Recoveries from Private Health Insurance Would Result in Substantial Savings (GAO/HRD-85-24, Feb. 1985). This average cost was reduced to $20 per bill in the cases of copayment billings for outpatient care, however. Because the average copayment for outpatient care would be far less than for inpatient care, it is expected that collection efforts would be considerably less extensive for these bills.

Several important assumptions were made in the development of this estimate. We assumed that the VA could implement the income eligibility criterion and copayment provisions fully within 90 days of enactment of the legislation. This assumption is based on statements to that effect contained in a letter, dated July 16, 1985, from John Ditzler, M.D., Chief Medical Director of the VA, to Mack Fleming, Chief Counsel and Staff Director of the House Veterans' Affairs Committee. Should significantly more time be required to implement the legislation, the fiscal year 1986 savings could fall considerably below the level estimated above.

Two additional assumptions were made regarding the implementation of this bill. First, it was assumed that the bill would not result in a significant increase in the use of contract care by the VA to provide care outside of the VA system. Because the bill does not substantively amend the current law restrictions on use of contract care, it was assumed that no more veterans would be considered eligible for and in need of contract care under this bill than under current law. Second, it was assumed that the change in eligibility standards would not affect the future hospital and nursing home construction plans of the VA. If the bill is interpreted by the VA to increase the government's obligation to provide medical care to broad categories of veterans, however, the agency could respond by increasing contract care and facility construction, which would offset a portion of the savings from this bill.

This estimate does not reflect the possibility that some additional demand for care could be induced by changes in the eligibility provisions of the bill or by the replacement of the poverty oath with a specific income test. This effect could not be included because the size and likelihood of the induced demand would be heavily dependent on the amount of publicity given to the changes by the VA and by veterans service organizations. This cannot be predicted with any certainty. Also, there is no data on which to base an estimate of the effect these amendments would have on the demand for care, even if the changes were highly publicized. The size of such induced demand, however, is not expected to be large. Nevertheless, any additional demands for care resulting from these provisions would reduce the savings generated by the bill.

Part B. Recovery of the Cost of Certain Care and Services.

This section would authorize the VA to recover from third-party health insurers the cost of medical care provided to insured veterans who have no service-connected disabilities.

(by fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Budget Authority	-203	-354	-403	-449	-500
Outlays	-203	-354	-403	-449	-500

Based on the GAO study of third-party reimbursement (GAO/HRD-85-24, Feb. 1985), it was assumed that 18.4 percent of the episodes of medical and surgical care in VA hospitals and 10.8 percent of episodes of psychiatric care would be provided to veterans with valid health insurance. Also based on this study, it was assumed that 85 percent, on the average, of the cost of care would be reimbursed by the insurer. An average cost for billing and collection activities of $30 per bill was used.

A factor not considered in this estimate is the possibility that the health insurers would fight the constitutionality of this legislation in the courts. In a 1979 review of a similar provision, S. 759, the Department of Justice concluded that there would be no constitutional bar to such legislation. Some delay in the receipt of recoveries would be expected, however, if the insurers choose to take the issue to the courts.

Part C. Limitation on Legislation Increasing Rates of Benefits.

This section would specify that no cost-of-living adjustment (COLA) in excess of 3.7 percent could be made in the benefit rates of disability compensation and dependency and indemnity compensation to be effective in fiscal year 1986.

(by fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Budget Authority	-34	-40	-39	-38	-37
Outlays	-30	-40	-39	-38	-37

The baseline of the First Concurrent Resolution on the Budget for fiscal year 1986 assumes a cost-of-living adjustment in compensation rates of 4.1 percent, which is estimated to cost $345 million in budget authority and $311 million in outlays in fiscal year 1986. By specifying that the COLA could not exceed 3.7 percent, this provision would result in the savings from the resolution baseline shown above. The provision would, however, have no effect on current law benefit rates or costs of the compensation program.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENT:

The Congressional Budget Office has determined that the budgets of state and local governments would not be directly affected by enactment of this bill.

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE:

On September 13, 1985, CBO submitted an estimate of the cost of H.R. 1538, the Veterans' Compensation and Health Care Amendments of 1985, to the House Committee on Veterans' Affairs. H.R. 1538 is the vehicle through which the House Veterans' Affairs Committee proposes to satisfy the expenditure reduction requirements of the first budget resolution. H.R. 1538 was estimated to result in the following savings from the budget resolution baseline:

(by fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Budget Authority	-274	-481	-537	-592	-652
Outlays	-274	-479	-529	-583	-643

There are a number of points of similarity and of difference between H.R. 1538 and the Senate-reported provisions. These are discussed below:

Compensation Rate Increase. H.R. 1538 would increase the rates of veterans' and survivors' compensation by 3.7 percent,effective December 1, 1985. The corresponding Senate provision would limit any future increase in rates effective in FY 1986 to a maximum of 3.7 percent. While both measures would effect the same savings from the resolution baseline, the Senate provision would have no affect on the current law costs of the compensation program. H.R. 1538 would actually raise compensation benefit rates by 3.7 percent and, thus, would raise current law costs for compensation by $311 million in 1986 budget authority and $280 million in outlays.

Income Eligibility Criterion and Copayments. The savings estimates for the income eligibility criterion and copayment provisions reported by the House and Senate Committees differ only by about $4 million. There are, however, a number of substantive differences between the two proposals, which are for the most part offsetting. For example, the income ceiling for the receipt of VA medical care in H.R. 1538 would be tied to the income standard for the VA pension program and, thus, would vary with family size. In the Senate bill, the income ceiling would be set at $25,000--the equivalent of the House ceiling for a veteran with one dependent--for all veterans regardless of family size. Since approximately 56 percent of the veteran patients in VA hospitals are unmarried, it is expected that significantly more veterans would qualify for free medical care under the Senate bill than under H.R. 1538. On the other hand, H.R. 1538 would cap the total annual reimbursements required of a veteran whose income exceeds the ceiling at an amount equal to the Medicare deductible. The Senate bill contains no such cap and, further, would require a coinsurance payment equal to the Medicare deductible for every 60 days, or portion thereof, of hospital or nursing home care. Thus, while fewer veterans would be expected to make copayments under the Senate bill than under the House bill, the amount of the average copayment required by the Senate bill would be higher than that required under H.R. 1538.

Third-Party Reimbursement. The provisions of H.R. 1538 and the Senate bill are substantively identical.

Other Provisions. H.R. 1538 contains some additional provisions not included in the Senate bill that would have only a minor budgetary impact.

9. ESTIMATE PREPARED BY: K.W. Shepherd (226-2820).

10. ESTIMATE APPROVED BY:

C.G. Nuckols
James L. Blum
Assistant Director
for Budget Analysis

SECTION-BY-SECTION ANALYSIS OF
TITLE XI -- VETERANS' PROGRAMS

PART A -- ENTITLEMENTS AND ELIGIBILITIES FOR HEALTH CARE FROM THE VETERANS' ADMINISTRATION

Section 1101

Would revise present section 610(a) of title 38, United States Code, relating to eligibility for hospital and nursing home care from the VA, to create a paragraph (1) providing as follows:

Division (i) of subparagraph (A) of paragraph (1) of revised section 610(a): Would require that the Administrator (except as provided in division (ii) of this subparagraph), through VA or other Government facilities or through contracts with private facilities, furnish such hospital care as the Administrator determines to be reasonably necessary to a veteran for a disability rated as service connected and for any disability of a veteran with a service-connected disability rated at 50 percent or more. Under current law, section 610(a)(1)(A), the Administrator "may" furnish hospital care to a veteran for a service-connected disability and to a veteran who is in receipt of disability compensation (or but for the receipt of retired pay would be entitled to disability compensation), which includes service-connected-disabled veterans rated from 10 through 100 percent disabled. There is no explicit requirement in current law to furnish care to any particular category of veterans or to furnish care for service-connected disabilities.

Also under current law, through the provision in section 610(a) authorizing the furnishing of care "within the limits of Veterans'

Administration facilities" and the definition of "Veterans' Administration facilities" in section 601(4) as including -- in addition to the VA's own facilities and Government facilities for which the VA contracts -- private facilities with which the VA may contract for hospital care or medical services in certain cases, the VA has authority to contract for such care in the applicable circumstances specified in section 601(4)(C).

The Committee provisions (in amendments made by section 1107 (discussed below)) would delete private contract facilities from that definition of "Veterans' Administration facilities". In lieu of that part of that definition, the Committee bill would add a new section 603 providing expressly that a requirement or authority in section 610 or in section 612, relating to outpatient medical services, to furnish hospital care or medical services includes a requirement or authority, as the case may be, to contract with non-VA facilities in order to provide care or services in certain circumstances. Those circumstances are identical to those specified in present section 601(4)(C) and include the universally applicable prequisite to the use of contract care that the VA be unable to furnish economical care directly because of geographic inaccessibility or be incapable of directly furnishing the care required.

The Committee notes that the use of the phrase "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title" or "as provided in section 620 of this title in the case of nursing home care" in lieu of the current law phrase "within the limits of Veterans'

Administration facilities" in this section -- as well as in other eligibility provisions with respect to hospital care (section 610(a)(1)(A), (B), and (C)), nursing home care (section 610(a)(2)(A) and (B)), domiciliary care (section 610(b)), and medical services (section 612(a), (f), and (g)) -- and the shifting of current law section 601(4)(C) to a new section 603 are not intended to change the effect of current law but rather to achieve greater clarity regarding the extent of eligibility for contract care (often referred to as "fee-basis" care). This new drafting formulation is also intended to clarify (as is the drafting of section 610(a)(2) (as proposed in section 1102(a) of the Committee provisions), relating to nursing home care, by the use of the phrase "or as provided in section 620 of this title") that the extent to which any fee-basis authority is provided is determined solely by what is in section 603 (or section 620 as to nursing home), in conjunction with other provisions of chapter 17, and that the Administrator's general authority to contract under current section 213 is not available with respect to any of these chapter 17 health-care authorities. The Committee construes the words "within the limits" in current law as providing the same limitation, but believes that the new formulation is more definitive in this regard.

In addition, the Committee notes that in revising the above-mentioned provisions relating to VA health-care eligibility, the criterion of "reasonably necessary" care has been used uniformly. Current law in some of these provisions uses a criterion of "needed" care or "in need of" care (section 610(a) and section 610(b)(2)) or "necessary or appropriate" care (section 612(a), second sentence, and section 612(f), second sentence). The Committee's use of the consistent terminology for this purpose is not intended to change the extent of current law in this respect.

Division (ii) of subparagraph (A) of paragraph (1) of revised section 610(a): Would provide that, in the case of a veteran who either is seeking care for a service-connected disability or has a service-connected disability rated at 50 percent or more, the Administrator, despite the general requirement in division (i) of this subparagraph to furnish hospital care to such a veteran, may decide not to furnish care in a VA facility if the veteran is incarcerated and the Administrator determines that so furnishing care is not feasible in terms of the security requirements that would be necessary for the custody of the veteran or the safety of other patients. Also, in the case of such a veteran, the Administrator would be authorized -- but not be required -- to furnish care through a contract with a non-VA facility. There are no provisions in current law expressly dealing with the furnishing of medical services to incarcerated veterans.

Subparagraph (B) of paragraph (1) of revised section 610(a): Would specify that the Administrator -- either through VA facilities or through non-VA facilities to the extent authorized in new section 603 (as proposed to be added by section 1107(b) (discussed below)) -- may furnish such hospital care as the Administrator determines to be reasonably necessary to veterans as described in five clauses as follows:

Clause (i) -- a veteran who has a service-connected disability rated at less than 50 percent (including a veteran with a non-compensable service-connected disability); a veteran who, but for the receipt of retired pay, would be entitled to VA disability compensation; a veteran who is entitled to disability compensation pursuant to section 351 of title 38 as a result of suffering an injury during VA care or while pursuing a VA program of vocational rehabilitation or, but for a suspension pursuant to that section, would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for VA care is not limited in the judgment or settlement described in section 351; and a veteran whose discharge or release from active duty in the Armed Forces was for a disability incurred or aggravated in line of duty.

Clause (ii) -- a veteran who is a former prisoner of war.

Clause (iii) -- a veteran exposed to a toxic substance in Vietnam or to radiation from a nuclear detonation, as provided for in present section 610(e).

Clause (iv) -- a veteran of the Spanish-American War, Mexican border period, or World War I.

Clause (v) -- for the non-service-connected disability of a veteran who is unable to defray the expenses of necessary care.

Under current law, each of the foregoing categories is eligible for hospital care directly from the VA and, to a limited extent, through contract facilities. This subparagraph recodifies current law in these respects

The Committee notes that the use of "may furnish" in this subparagraph (as well as in subparagraph (C) of this paragraph and in other health-care eligibility provisions in sections 610(a)(2)(B), 610(b), and 612(f)(1) and (2)) provides the same eligibility as under current law to the categories of veterans covered -- essentially eligible veterans other than those requiring care for a service-connected disability and; for any disability, those with 50-percent-or-more service-connected disabilities, for which categories an entitlement to hospital care and medical services (and in the case of the former category for nursing home care as well) is established by virtue of the amendments made to section 610(a)(1)(A) by this section of the Committee legislation -- for hospital care, domiciliary care (as to all veterans), nursing home care, and medical services. The only eligibility change that is made (other than as noted above regarding the establishment of an entitlement) is with respect to section 610(a)(1)(C) (discussed below) regarding veterans with incomes over $25,000 per year.

Subparagraph (C) of paragraph (1) of revised section 610(a): Would specify that the Administrator may furnish such hospital care, either through VA facilities or non-VA facilities to the extent authorized in new section 603, to the extent facilities and resources are otherwise available for providing such care and subject to new subparagraph (D) of this paragraph (discussed below) for a non-service-connected disability of a veteran who agrees to make payment to the United States under new section 612B of title 38, as added by section 1105 of the Committee legislation (discussed below).

The Committee notes that by virtue of this provision, in conjunction with new subsection (b) of section 622 (as proposed to be added by section 1106(a)(4) of the Committee legislation, discussed below), a veteran with annual family income over $25,000 who is 65 years of age or older would still be eligible for VA care (on a space-available basis) upon agreement to make a modest payment prescribed in new section 612B (as proposed to be added by section 1105(a)(11) and (b)(2) (as proposed to be added by such section 1105(a)) would be afforded priority ahead of a veteran with annual family income over $25,000 who is under age 65).

The Committee notes that with respect to this category of eligibility the Committee does not intend that beneficiary travel -- which under present section 111 of title 38 (and by virtue of present section 601(b)(ii)) is discretionary -- be paid or that, in the absence of extraordinary circumstances, appliances as described in the definition of "medical services" in current section 601(6)(A)(i) be provided. The Committee also notes its intention that the eligibility of this category of veterans on a space-and-resources-available basis should not be taken into account for purpose of planning, budgeting, or appropriations for the VA health-care system.

Further, the eligibility of this category of veterans for care under section 612(f)(1) "to obviate the need of ... hospital admission" would be the lowest order of priority and would be strictly on a space-and-resources-available basis.

Finally, the Committee notes that, although a veteran with annual family income of $25,000 would generally be eligible for care or services only upon the veteran (or someone authorized to act for him or her) agreeing to pay for those services before they are provided, the VA has full authority under current section 611(b) to furnish hospital care or medical services in emergency cases and to charge appropriately for such care, and that this emergency authority would be applicable in the case of a veteran in this category of eligibility who is unable to execute such an agreement prior to the commencement of care.

Subparagraph (D) of paragraph (1) of revised section 610(a): Would authorize the Administrator to prescribe regulations under which a veteran with an annual family income above an amount specified in the regulations or an estate with a corpus above an amount so specified would not be eligible, despite being willing to agree to make payment to the United States, to receive care under new subparagraph (C) of this section (described above). For the purpose of this subsection, the Administrator would be required to determine income in accordance with section 503 of title 38, relating to income determinations for the current VA pension program, and, in so doing, to count as income of the veteran any income of the veteran's family member that would be taken into account under section 521(c) of title 38, relating to the amount of VA pension that a veteran is entitled to receive. With reference to this authority and the comparable authority with regard to nursing home care in section 610(a)(2)(C) as proposed to be revised by section 1102 of the Committee legislation (discussed below), the Committee expects that the Administrator would generally, as has been done for purposes of the pension program, disregard the value of the veteran's primary residence as well as of a vehicle used for transportation purposes.

Section 1102

Would further amend present section 610(a) to create a paragraph (2) providing as follows:

Subparagraph (A) of paragraph (2) of revised section 610 (a): Would require the Administrator to furnish such nursing home care as the Administrator determines to be reasonably necessary to a veteran for a service-connected disability. The Administrator would provide such nursing home care through VA facilities or through non-VA facilities as provided for in section 620 of title 38, which authorizes the Administrator, under specified circumstances, to provide nursing home care in non-VA facilities. Under current law, nursing home care is authorized for such disabilities, but there is no explicit requirement in this regard.

Subparagraph (B) of paragraph (2) of revised section 610(a): Would specify that the Administrator may furnish such nursing home care -- either through VA facilities or through non-VA facilities as provided for in section 620 -- as the Administrator determines to be reasonably necessary to any veteran eligible for hospital care under subparagraphs (A) and (B) of paragraph (1) of this subsection (described above), for any disability other than a service-connected disability. This provision restates the VA nursing home care eligibility in current law with respect to the veterans described in those paragraphs.

Subparagraph (C) of paragraph (2) of revised section 610(a): Would specify that the Administrator may furnish such nursing home care, either through VA facilities or through non-VA facilities, to the extent facilities and resources are otherwise available to provide such care and subject to new subparagraph (D) of this this paragraph (discussed below), to a veteran eligible for hospital care under subparagraph (C) of paragraph (1) of this subsection (described above) who agrees to make payment to the United States under new section 612B of title 38, as added by section 1105 of this Act (described below). (See the discussion of paragraph (1)(C) of revised section 610(c), above, regarding the effect of this provision in conjunction with certain other provisions in providing for eligibility for VA care in the cases of veterans with annual family incomes above $25,000.)

Subparagraph (D) of paragraph (2) of revised section 610(a): Would authorize the Administrator to prescribe regulations under which a veteran with an annual family income above an amount specified in the regulations or an estate with a corpus above an amount so specified would not be eligible, despite being willing to agree to make payment to the United States, to receive care under new subparagraph (C) of this subsection (described above). For the purpose of this subsection, the Administrator would be required to determine income in accordance with section 503 of title 38, relating to income determinations for the current VA pension program, and, in so doing, to count as income of the veteran any income of the veteran's family member that would be taken into account under section 521(c) of title 38, relating to the amount of VA pension that a veteran is entitled to receive.

Section 1103

Would amend present section 610(b) of title 38, relating to eligibility for VA domiciliary care, to authorize the Administrator to furnish such domiciliary care as the Administrator determines to be reasonably necessary to a veteran if the Administrator finds, pursuant to regulations which the Administrator would be required to prescribe, that the veteran is incapacitated from earning a living and has no adequate means of support. This resource standard is the same standard as exists in clause (1) of present section 610(b), which relates to domiciliary care for veterans with service-connected conditions and is the standard generally applied under current VA regulations (38 C.F.R. 17.47(c)(3) and (d)(3)). (The reference in current clause (2) to eligibility on the basis of inability to defray the expenses of necessary domiciliary care is no longer appropriate, as a domiciliary-care eligibility criterion, in view of the definition of such inability, in new subsection (b) of section 622 (as proposed to be added by section 1106(a) of the Committee legislation), as meaning having an annual family income of $25,000 or less.) Thus, this amendment has the effect of establishing a single statutory standard by which the resources of a veteran seeking domiciliary care will be determined.

Section 1104

Would amend present section 612 of title 38, relating to eligibility for ambulatory or outpatient medical services, to establish new eligibility criteria for certain veterans and to make other changes to that section.

Subclause (A) of clause (1) of subsection (a) of section 1104 would redesignate subsection (a) of present section 612 as paragraph (1) and amend the first sentence thereof, relating to the eligibility of a veteran for medical services for a service-connected disability, so as to require the Administrator (except as specified in new paragraph (1) of this subsection (discussed below), relating to incarcerated veterans, and in subsection (b) of section 612, relating to outpatient dental services) to furnish such medical services as the Administrator determines to be reasonably necessary (1) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged from the Armed Forces) and (2) to a veteran who has a service-connected disability rated at 50 percent or more. The Administrator would be required to furnish the services through VA or other Government facilities or contracts with private facilities.

Under current law, the Administrator "may" furnish medical services to a veteran for a service-connected disability (under present section 610(a)) and to a veteran with a service-connected disability rated at 50 percent or more (under present section 612(f)(2)), but there is no explicit requirement in current law to furnish medical services to any particular category of veterans or to furnish medical services for service-connected disabilities.

Subclause (B) of clause (1) of subsection (a) of section 1104 would amend the second sentence of present subsection (a) of section 612, relating to the eligibility of a veteran for home health services for a service-connected disability, so as to make a clarifying change specifying that the home health services described in that sentence are provided to the veteran "as part of" the medical services furnished under the first sentence of subsection (a) of section 612 and, by cross-reference to that sentence, to require that such home health services as the Administrator finds necessary or appropriate be furnished for a veteran for a service-connected disability or for any disability of a veteran with a service-connected disability rated at 50 percent or more. As in the case of medical services generally, as discussed above with respect to the amendment made by subclause (B) of this clause, there is no express requirement in current law for the furnishing of home health services in any circumstances.

Subclause (C) of clause (1) of subsection (a) of section 1104 would delete the third sentence of subsection (a) of present section 612 -- relating to eligibility for medical services for a disability which was incurred or aggravated in line of duty and for which the veteran was discharged -- as a conforming amendment in connection with the amendment proposed to be made by subclause (A) of this clause to the first sentence of subsection (a) of section 610, pursuant to which the substance of the third sentence is included in the first sentence of such subsection (a).

Subclause (D) of clause (1) of subsection (a) of section 1104 would add to section 612(a) a new paragraph (2), as follows:

New paragraph (2) of section 612(a): Would provide that, in the case of a veteran who either is seeking care for a service-connected disability or has a service-connected disability rated at 50 percent or more, the Administrator, despite the general requirement in the first sentence of paragraph (1) of section 612(a) (as proposed to be amended by subclause (A) of this clause of the Committee legislation) to furnish medical services to such a veteran, may decide not to furnish medical services in a VA facility if the veteran is incarcerated and the Administrator determines that so furnishing such services is not feasible in terms of the security requirements that would be necessary for the custody of the veteran and the safety of other patients. Also, in the case of such a veteran, the Administrator would be authorized -- but not required -- to furnish care through a contract with a non-VA facility. There are no provisions in current law expressly dealing with the furnishing of medical services to incarcerated veterans.

Division (i) of subclause (A) of clause (2) of subsection (a) of section 1104 would amend the first sentence of subsection (f) of present section 612, relating to the eligibility of a veteran for medical services for other than a service-connected disability, so as to delete the phrase specifying that the services furnished pursuant to that section are to be furnished "within the limits of Veterans' Administration facilities" and replacing it with a phrase specifying that the services are to be furnished "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603" of title 38. An explanation of an identical non-substantive change and the reasoning behind it is provided in the above discussion of subparagraph (A) of paragraph (1) of section 610(a), as proposed to be revised by section 1101 of the Committee legislation.

Divisions (ii), (iii), and (iv) of subclause (A) of clause (2) of subsection (a) of section 1104 would further amend the first sentence of subsection (f) of present section 612, so as to delete clause (2), relating to the eligibility for medical services of a veteran with a service-connected disability rated at 50 percent or more, and to make appropriate conforming changes. This deletion of clause (2) conforms the first sentence of subsection (f) with the provisions of clause (1) of subsection (a) of this section of the Committee legislation which amend the first sentence of section 612(a) so as to provide the same category of veterans with entitlement to medical services.

Subclause (B) of clause (2) of subsection (a) of section 1104 would amend the second sentence of present subsection (f) of section 612, relating to the eligibility of certain veterans for home health services for other than a service-connected disability, so as to make a clarifying change (similar to the one made in the third sentence of section 612(a) by clause (1) of subsection (a) of this section of the Committee legislation) specifying that the home health services described in that sentence are provided to veterans "as part of" the medical services furnished under the first sentence of subsection (f) of section 612.

Subclause (C) of clause (2) of subsection (a) of section 1104 would amend the third sentence of subsection (f) of present section 612, relating to the Administrator's authority to furnish outpatient dental care to certain veterans who are former prisoners of war, so as to delete the phrase specifying that the care furnished pursuant to that sentence is to be furnished "within the limits of Veterans'

Administration facilities" and replace it with a phrase specifying that care is to be furnished "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603" of title 38. An explanation of this particular type of non-substantive change and the reasoning behind it is provided in the above discussion of subparagraph (A) of paragraph (1) of section 610(a), as proposed to be revised by section 1101 of the Committee legislation.

Clause (3) of subsection (a) of section 1104 would amend subsection (g) of present section 612, relating to the eligibility for medical services of certain veterans -- veterans of the Mexican border period or of World War I and those who are in receipt of or, but for the receipt of retired pay, would be in receipt of increased VA pension or additional compensation based on needing regular aid and attendance or being permanently housebound -- so as to delete the phrase specifying that the services furnished are to be furnished "within the limits of Veterans' Administration facilities" and replace it with the phrase "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603" of title 38. An explanation of this particular type of non-substantive change and the reasoning behind it is provided in the above discussion of subparagraph (A) of paragraph (1) of section 610(a), as proposed to be revised by section 1101 of the Committee legislation.

Clause (4) of subsection (a) of section 1104 would further amend section 612 by deleting subsection (i), relating to the priority that the Administrator is to accord in providing medical services, and by redesignating present section (j) of section 612 as subsection (i). The deletion of that subsection would be a conforming change in connection with the addition of new section 612C of title 38, as proposed to be added by section 1105 of the Committee legislation (discussed below), which would prescribe the order of priority for the furnishing of VA hospital, nursing home, and domiciliary care and medical services.

Subsection (b) of section 1104 would amend present section 612A of title 38, relating to eligibility for readjustment counseling and related mental health services, to replace the phrase "within the limits of Veterans' Administration facilities" in subsection (a) and (b)(1) with the phrase "through Veterans' Administration facilities" and, in subsection (e)(1), to substitute new cross references (to sections 612(a)(2) and 603(2)(A)) in order to conform to amendments made by other secitons of the Committee legislation (subsection (a) of this section and section 1107, respectively). None of the amendments made by this subsection would have any substantive effect.

Section 1105

Subsection (a) of section 1105 would amend present subchapter II of chapter 17 of title 38, relating to VA hospital, nursing home, or domiciliary care and medical services, to add two new sections, section 6132B entitled "Payment in connection with hospital and nursing home care and medical services", and section 612B entitled "Priorities in furnishing hospital, nursing home, and domiciliary care and medical services", as follows:

Paragraph (1) of subsection (a) of new section 612B: Would provide that a veteran who is eligible for hospital, nursing home, or domiciliary care under section 610 of title 38, or for medical services under section 612(f)(1) of title 38, because of section 610(a)(1)(C) or (2)(C) (as added by sections 1101 and 1102 of the Committee legislation, respectively), relating to the eligibility for VA care and services (to the extent facilities and resources are otherwise available) of veterans who are not determined to be income eligible (that is, unable to defray the cost of necessary care), would not be furnished care or services unless the veteran agrees to make a specified payment to the United States in connection with receiving such care. Pursuant to clause (A) of this paragraph, the required payment in the case of each 60 days of hospital or nursing home care within an episode of hospital care or nursing home care -- as defined in subsection (c) of new section 612B (described below) -- would be an amount equal to the lesser of the Medicare inpatient hospital deductible in effect under section 1813 of the Social Security Act (42 U.S.C. 1395e(b)) at the time the care is provided or the cost of furnishing the care, as determined by the

Administrator. The Medicare inpatient hospital deductible in fiscal year 1986 is estimated to be $476.

With reference to each visit for outpatient or ambulatory care, clause (B) would provide that such a veteran would be required to make a payment equal to a specified percentage of the estimated average cost of a VA outpatient visit during the fiscal year in which the services are furnished. The specified percentage would be the percentage of reasonable charges not paid under Medicare Part B for non-hospital care pursuant to section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1). The percentage payable by the veteran, as so derived from the Social Security Act, would be 20 percent. The Administrator would have discretion to determine what would constitute a "visit" for outpatient purposes.

The Committee intends that any veteran seeking VA care for a non-service-connected disability on the basis of the veteran's "inability to defray expenses" would execute a written agreement to make the prescribed payments to the VA in the event that it is not determined that the veteran is unable to defray the cost of necessary care.

Paragraph (2) of subsection (a) of new section 612B: Would provide that in any case in which the Administrator determines that it is not feasible to request a veteran (or other individual acting on behalf of a veteran) to pay the VA as required by paragraph (1) (discussed above), an obligation to make payments would nevertheless be established.

Subsection (b) of new section 612B: Would specify that any moneys collected or received by the VA under this section would be deposited in the Treasury as miscellaneous receipts. The Committee notes that, as is the case with respect to collections under section 629 of title 38 (as proposed to be revised by section 1111 of the Committee legislation, discussed below) moneys so collected or received would not be used or available to reduce the budget or appropriations for the VA health-care system.

Paragraph (1) of subsection (c) of new section 612B: Would define, for the purpose of subsection (a) of this section, the term "episode of hospital or nursing home care" to mean a period of consecutive days beginning with the first day (not included in a prior episode of care) on which a veteran is furnished hospital or nursing home care under subchapter II of chapter 17 of title 38, and ending at the close of the first period of 60 consecutive days thereafter on each of which the veteran is not being furnished either such hospital care or nursing home care. Thus, an episode of care is ended only when the veteran has been discharged from care for 60 consecutive days.

Paragraph (2) of subsection (c) of new section 612B: Would define, for the purpose of subsection (a) of this section, the term "60 days of care" to mean (A) in the case of a veteran who during an "episode of hospital or nursing home care" (as that term is defined in paragraph (1) of this subsection) is furnished 60 or fewer days of care, up to 60 days of hospital or nursing home care (or of any combination of days of such care) or (B) in the case of a veteran who during such a defined "episode of hospital or nursing home care" is furnished care for a number of days greater than 60, each period of hospital or nursing home care (or of any combination thereof) of 60 days and, if the total number of days cannot be evenly divided by 60, any remaining period of care that is less than 60 days.

The following examples demonstrate the operation of the payment provisions in new section 612B. In each example the veteran is a non-service-connected-disabled veteran with family income in excess of $25,000 who is eligible for VA care only upon agreeing to make payment to the VA in connection with the care. All care is provided directly in VA hospitals or nursing homes.

Example A

The veteran receives 5 days of hospital care from the VA and, in connection with that care, pays the VA an amount equal to the Medicare inpatient hospital deductible (estimated to be $476 in fiscal year 1986). Six months later the veteran is again admitted for 5 days of care.

Because a period of more than 60 consecutive days has elapsed since the veteran's initial hospitalization, the veteran has entered a second "episode of hospital or nursing home care" (as defined in subsection (c)(1) of new section 612B) and, thus, in order to be eligible, must have agreed to pay the VA a second amount equal to the Medicare inpatient hospital deductible.

Total payments by the veteran: $952.

Example B

The veteran suffers a stroke and is admitted to a VA hospital for a period of 35 days. At the end of the hospitalization, the veteran is admitted to a nursing home and discharged after 26 days. The veteran is readmitted to the hospital, 45 days after being discharged from the nursing home, for 3 days of care for a medical condition unrelated to the stroke.

In this example, all of the care was furnished within one "episode of hospital or nursing home care" because, from the day when the veteran first entered the hospital, there was not a period of 60 consecutive days during which the veteran did not receive either hospital or nursing home care through the VA. At the time of the veteran's initial hospital admission, the veteran agreed to make payment to the VA and, because the cost of the veteran's treatment exceeded the Medicare inpatient hospital deductible, the veteran was required to pay the VA an amount equal to that amount. At the time the veteran was transferred to the VA nursing home, the veteran had only been under VA care for 35 days. Thus, the first 25 days of the VA nursing home care were covered by the veteran's payment in connection with the initial "60 days of care". The 26th and final day of nursing home care would, however, come under a second period of "60 days of care" and, because the cost of that day (currently, the cost of each day of VA nursing home care is approximately $112) would be less than the Medicare inpatient hospital deductible, the veteran would pay that smaller amount, the actual cost of the care. At the time of the veteran's rehospitalization 45 days after discharge from the nursing home, the veteran was still in the same "episode of hospital or nursing home care", even though the hospitalization was for a different condition, and still receiving care in connection with the second "60 days of care". However, the cost of the subsequent 3 days of inpatient care exceeded the Medicare hospital inpatient deductible, so the veteran became responsible for making a second $476 payment to the VA. The amount previously paid ($112) in connection with the second "60 days of care" would be counted toward the veteran's satisfaction of the payment requirement, leaving a balance due of $364.

Total payments by the veteran: $952.

Example C

A veteran is hospitalized for 3 days for the purpose of undergoing diagnostic tests, thereby beginning an "episode of hospital or nursing home care" for which the veteran agrees to make payment to the VA. Six weeks later, the veteran is readmitted to the hospital for 4 days for exploratory surgery. Five weeks after being discharged from that admission, the veteran is again admitted, this time for 14 days for major surgery and treatment. Following that admission, the veteran is discharged to a community nursing home where the veteran receives 180 days of care at VA expense.

Because the veteran never experienced a period of 60 consecutive days after the initial hospital admission during which the veteran received neither hospital nor nursing home care through the VA, the entire period of care in this example is one "episode of hospital or nursing home care" during which the veteran received a total of 201 days of care. Those days of care equal four periods of "60 days of care" -- three full 60 day periods and a final 21 day period -- for each of which the veteran would make a payment to the VA equal to the Medicare inpatient hospital deductible.

Total payments by the veteran: $1,904.

Subsection (a) of new section 612C: Would require the Administrator to prescribe regulations setting forth the priority order to be followed in furnishing VA hospital or domiciliary care or medical services. This order, which would be followed except in cases involving medical emergencies which pose a serious threat to life or health, would be as follows:

(1) To a veteran for a service-connected disability.

(2) To a veteran with a service-connected disability rated at 50 percent or more.

(3) To a veteran who has a service-connected disability rated at less than 50 percent but which is compensable in degree -- including any veteran who is being examined to determine the existence or rating of a service-connected disability, for the purpose of the examination (the same language in section 612(i)(3) has been determined to include pension, as well as compensation, eligibility examinations).

(4) To a veteran who, but for the receipt of retired pay, would be entitled to disability compensation.

(5) To a veteran who is entitled to disability compensation pursuant to section 351 of title 38 (as a result of suffering an injury during VA care or while pursuing a VA program of vocational rehabilitation) or who, but for a suspension of compensation payments under that section, would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for VA care is not limited by the judgment or settlement described in section 351.

(6) To a veteran (A) whose discharge or release from active duty in the Armed Forces was for a disability incurred or aggravated in line of duty, or (B) with a disability which is service-connected but which is not compensable in degree.

(7) To a veteran (A) who is a former prisoner of war, or (B) who was exposed to a toxic substance in Vietnam or radiation from a nuclear detonation who is eligible for care under new section 610(a)(1)(B)(iii), as added by section 1101 of the Committee legislation (described above), for care as specified in present section 610(e) of title 38.

(8) To a veteran of the Spanish-American War, the Mexican border period, or World War I, or who is otherwise being furnished VA services under present section 612(g) of title 38, by reason of being in receipt of (or who, but for the receipt of retired pay, would be in receipt of) increased VA pension or additional compensation or allowance based on needing regular aid and attendance or being permanently housebound.

(9) To a veteran in receipt of VA pension under chapter 15 of title 38.

(10) To a veteran who is unable to defray the expenses of necessary care.

(11) To a veteran being furnished care or services because of section 610(a)(1)(C) or (2)(C) of title 38, as added by sections 1101 and 1102 of the Committee legislation (described above), who is 65 years of age or older.

Under current law, the only express statutory requirement for priorities, in section 612(i), relates to the furnishing of outpatient medical services and requires that VA regulations ensure that, except for medical emergencies, priority be accorded in the following order to:

(1) A veteran for a service-connected disability.

(2) A veteran described in item (2), above.

(3) A veteran described in item (3), above.

(4) A veteran described in item (7), above.

(5) A veteran described in item (8), above.

Subsection (b) of new section 612B: Would require the Administrator to prescribe regulations which would set forth the priority categories to be followed in furnishing VA nursing home care. The regulations would be required to establish two overall priority categories and specify that within each of those categories the priority order required under subsection (a) of this new section (discussed above) must be followed. The two overall categories are (1) care in a VA-run facility for a veteran in need of a level or type of nursing home care that is not readily available in the appropriate geographic area in a non-VA nursing home with which the VA can contract but which is available in a VA nursing home and (2) care for a veteran in need of a level or type of care that is readily available in the appropriate geographic area in such a non-VA nursing home.

Subsection (c) of new section 612B: Would require the Administrator to ensure that no VA guideline, regulation, or other issuance has the effect of encouraging, directly or indirectly, the furnishing of care or services in any fashion not consistent with the priorities established pursuant to subsections (a) and (b) of this new section to veterans eligible for such care or services under paragraph (1)(C) or (2)(C) of section 610(a) of title 38 (as proposed to be revised by sections 1101 and 1102 of the Committee legislation (discussed above)), relating to eligibility for VA care based on agreement to pay for a portion of the cost.

Subsection (b) of section 1105 would amend the table of sections at the beginning of Chapter 17 to reflect the addition of new sections 612B and 612C proposed by subsection (a) of this section.

Section 1106

Would amend present section 622, relating to the determination of a veteran's ability to defray necessary expenses, to redesignate the existing provision as subsection (a); to change a cross-reference in that provision from "610(a)(1)(B)" to "610(a)(1)(B)(v)" to reflect a change in designation made by section 1101 of the Committee legislation (discussed above); to delete a cross-reference to section 610(b)(2), relating to domiciliary care, as no longer appropriate as a result of a change in that section made by section 1103 of the Committee legislation (discussed above); and to add a new subsection (b), providing that veterans with family incomes below certain levels will be generally determined to be unable to defray the cost of their care, as follows:

Subparagraph (A) of paragraph (1) of new subsection (b) of section 622: Would provide that -- subject to subparagraph (B) of this paragraph, relating to inflation adjustments in the income eligibility criterion, and except as provided in paragraph (3) of this new subsection, relating to determinations that as a result of the amount of the veteran's assets the veteran is not income eligible (that is, unable to defray the costs of necessary care) -- the Administrator would be required to determine that a veteran with a family income of $25,000 or less during the calendar year preceding the date of the veteran's application for VA care is unable to defray the expenses of necessary care. As discussed above in connection with the provision relating to eligibility for hospital care (paragraph (1)(B)(v) of section 610(a), as proposed to be revised by section 1101 of the Committee legislation), such a determination of inability to defray provides eligibility for VA hospital care and -- by virtue of the derivative eligibility for nursing home care and medical services for veterans eligible for hospital care (in paragraph (2)(B) of section 610(a), as so proposed to be revised, and in section 612(f), both in current law and as proposed to be amended by section 1104(a)(2) of the Committee legislation) -- for VA nursing home care and medical services.

Provisions of current law do not specify such an income eligibility criterion. However, provisions in current law (section 622(a)(1), (2), and (3)) not amended by the Committee legislation specify that veterans who are eligible for Medicaid, who have a service-connected disability, or who are in receipt of VA pension are deemed to be eligible by reason of inability to defray necessary expenses.

Division (i) of subparagraph (B) of paragraph (1) of new subsection (b) of section 622: Would require that, after December 1, 1985, the $25,000 income eligibility criterion established under subparagraph (A) of this paragraph be increased by the same percentage and effective on the same date as maximum annual rates of VA pension under chapter 15 of title 38 are increased pursuant to section 3112(a) of title 38.

Division (ii) of subparagraph (B) of paragraph (1) of new subsection (b) of section 622: Would authorize the Administrator, pursuant to regulations which the Administrator would be required to prescribe and in order to avoid hardship, to increase for a specified geographic area in any fiscal year the income level established under subparagraph (A) of this paragraph (and as increased under division (i) of this subparagraph (discussed above)).

Paragraph (2) of new subsection (b) of section 622: Would specify that, for the purpose of this new subsection, the Administrator must determine a veteran's income in accordance with section 503 of title 38.

relating to income determinations for VA pension purposes, and must count as income of the veteran any income of the veteran's family members that would be taken into account under section 521(c) of title 38, relating to the computation of the amount of VA pension that a veteran is entitled to receive.

Subparagraph (A) of paragraph (3) of new subsection (b) of section 622: Would prohibit the Administrator from making a determination that a veteran is unable to defray necessary medical expenses if the corpus of the estate of the veteran (and of the veteran's spouse and dependent children, if any) is such that, under all the circumstances (including consideration of the income of the veteran and the veteran's family members), the Administrator finds it is unreasonable to make such a determination.

Subparagraph (B) of paragraph (3) of new subsection (b) of section 622: Would require the Administrator, in evaluating the corpus of a veteran's estate for the purpose of this paragraph to consider the same items to be part of the corpus as would be so considered in making a determination under section 522 of title 38, relating to determinations of net worth for the purpose of eligibility for VA pension. In this connection, the Committee expects that the Administrator would generally, as is done for purposes of the pension program, disregard the value of the veteran's primary residence as well as of a vehicle used for transportation purposes.

Generally as to this new section, the Committee intends that as nearly as practicable income and determinations with respect to the new income eligibility criterion be made in the same manner as for purposes of the VA improved pension program carried out under chapter 15 of title 38 and that such determinations be made annually at the time that a veteran first applies each year for VA care.

Section 1107

Paragraph (1) of subsection (a) of section 1107 would amend paragraph (4) of section 601 of title 38, relating to the definition of "Veterans' Administration facilities", to delete clause (C) in connection with the amendment made by subsection (b) of this section of the Committee legislation, which incorporates the text of present clause (C) in a new section 603 which would be added by subsection (b)(1) of this section of the Committee legislation (discussed below).

Paragraph (2) of subsection (a) of section 1107 would add a new paragraph (9) to section 601, to define the term "non-Veterans' Administration facilities" to mean facilities other than "Veterans' Administration facilities", a term defined in paragraph (4) of section 601 as proposed to be amended by paragraph (1) of this subsection (discussed above).

Paragraph (1) of subsection (b) of section 1107 would amend subchapter I of chapter 17, relating to general matters concerning the VA health-care system, to add a new section 603, entitled "Contract hospital care and medical services", as discussed below. As noted above under the discussion of paragraph (1) of subsection (a) of this section of the Committee legislation, the text of new section 603 is derived directly from present clause (C) of section 601(4). The rationale for making this revision -- which is not intended to change present law in any substantive way -- is explained in the above discussion of the revision of section 610(a) proposed to be made by section 1101 of the Committee legislation.

New section 603: Would provide that in cases in which VA facilities are not capable of furnishing economical hospital care (because of geographic inaccessibility) or of furnishing care or services required, a requirement (as to a service-connected disabled veteran for a service-connected disability or to a veteran with a disability rated at 50 percent or more) or an authority in section 610 (relating to hospital, nursing home, or domiciliary care) or section 612 (relating to outpatient or ambulatory care) includes a requirement or authority, as the case may be, to contract with non-VA facilities for the furnishing of hospital care or medical services as specified in clauses (1) through (6), as follows:

Clause (1) -- Hospital care or medical services for a service-connected disability or for a disability for which a veteran was discharged from active service.

Clause (2) -- Medical services (A) for any disability of a veteran with a service-connected disability rated at 50 percent of more, (B) for any disability of a veteran who has been discharged from a VA hospital and is in need of post-hospital outpatient care (for up to twelve months) to complete the treatment which was begun in the hospital, (C) limited to dental services, treatment, and related appliances for a veteran who is a former prisoner of war who was interned for at least six months, or (D) for any disability of a veteran of the Mexican border period or of World War I or who is in receipt of (or, but for the receipt of retired pay, would be in receipt of) increased VA pension or additional compensation or allowance based on the need of regular aid and attendance or on being permanently housebound, if the medical condition of the veteran precludes treatment in VA facilities.

Clause (3) -- Hospital care or medical services in medical emergencies which pose a serious threat to the life or health of a veteran receiving care or services in a VA facility, until such time as the veteran can be safely transferred back to a VA facility.

Clause (4) -- Hospital care for women veterans.

Clause (5) -- In Alaska, Hawaii, the Commonwealth of Puerto Rico, and the Territories and possessions of the United States, and within certain limitations, hospital care or medical services that would obviate the need for hospital admission.

Clause (6) -- Diagnostic services necessary for determining eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent VA outpatient clinics to obviate the need for hospital admission.

The final sentence of new section 603 would require the VA to review periodically the necessity for continuing a contract entered into under this section.

With respect to clause (3) of new section 603, which is derived directly from clause (C)(ii) of section 601(4), the cross-reference which is construed as creating contract dental care eligibility for former prisoners of war who had at least six-month internments ("any disability of a veteran described . . . in the third sentence of . . . section 612(g)") has been modified by inserting "(but only to the extent authorized therein)" after the section reference. This modification clarifies that the ex-POW contract eligibility therein provided is only in connection with the dental treatment described and authorized in the third sentence of section 612(f) (which makes reference back to the limitation established in section 612(b)(1)(G) on the furnishing of dental care).

Subsection (b) of section 1107 would amend the table of sections at the beginning of chapter 17 to reflect the addition of new section 603 proposed by subsection (a) of this section.

Section 1108

Would require the Administrator, not later than December 1, 1985, to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the procedures that the Administrator would by then have established to implement new section 612B of title 38, relating to payment by certain veterans in connection with VA care (as added by section 1105 of the Committee legislation, discussed above). This report would be required to provide information regarding the guidelines and processes for implementing the income eligibility criterion and other criteria for determing VA health-care eligibility established by or under the amendments made by this Part of the Committee legislation and for the collection of payments pursuant to these amendments.

Section 1109

Subsection (a) of section 1109 would provide that, except as set forth in subsection (b) of this section, the amendments made by this Part of the Committee legislation shall apply to hospital care, nursing home care, domiciliary care, and medical services furnished on or after November 1, 1985.

Paragraph (1) of subsection (b) of section 1109 would provide that the provisions of section 610, relating to eligibility for VA hospital care, nursing home care, or domiciliary care, and section 622, relating to determinations regarding veterans' inability to defray the cost of necessary care, as in effect on the day before the date of the enactment of the Committee legislation shall apply with respect to hospital and nursing home care furnished on or after November 1, 1985, to veterans who were furnished such care on October 31, 1985, but only to the extent that such care is furnished with respect to the same period of care -- defined in paragraph (3) of this subsection as ending on the date the veteran is discharged from the hospital or nursing home -- for which such care was being furnished on October 31, 1985. Thus, a veteran being furnished hospital or nursing home care on October 31, 1985, could continue to receive such care under the same terms and conditions that applied under the law in effect when he or she was admitted, but only until he or she is discharged from the hospital or nursing home facility. Thereafter, as to any subsequent period of care, the amendments made by this Part of the Committee legislation would apply.

Paragraph (2) of subsection (b) of section 1109 would authorize the Administrator, during the month of November 1985, to continue to provide medical services on an ambulatory or outpatient basis to a veteran who was receiving such services prior to November 1, 1985, without regard to the amendments made by this Part, in order to continue a course of treatment.

Paragraph (3) of subsection (b) of section 1109 would define, for the purpose of this subsection, the terms" period of care" (as noted above under the discussion of paragraph (1)), to mean a period of care ending on the date a veteran is discharged from the hospital or nursing home facility); "hospital care", "medical services", and "domiciliary care" (to have the meanings given those terms in paragraphs (5), (6), and (8), respectively, of section 601 of title 38); and "veteran" and "nursing home care" (to have the meanings given those terms in paragraphs (2) and (28), respectively, of section 101 of title 38).

PART B -- RECOVERY OF THE COST OF CERTAIN HEALTH CARE AND SERVICES FURNISHED BY THE VETERANS' ADMINISTRATION

Section 1111

Subsection (a) of section 1111 would amend present section 629 of title 38, relating to the United States' authority generally to recover the reasonable costs of Veterans' Administration-furnished non-service-connected health care from workers' compensation insurance carriers (or self-insured employers), automobile accident reparation (auto no-fault) insurance carriers, or State or local crime victims' compensation programs, where the carrier (or employer) or program would be liable to a non-Federal Government provider. Revised section 629 would add authority for the VA to recover from health insurers the reasonable costs of VA care furnished (directly in VA facilities, in other Government facilities, or in other facilities under contract with the VA) to insured veterans who have no service-connected disabilities. Although in proposing to expand the coverage of section 629 the Committee provisions would restructure that section, except as noted below no substantive changes in current law are intended with respect to the right to recover from the entities specified in present section 629. Section 629 would be revised as follows:

Paragraph (1) of subsection (a) of revised section 629: Would provide that the United States has the right to recover or collect the reasonable cost of care or services furnished directly or under contract by the VA to veterans, for non-service-connected disabilities described in paragraph (2) of this subsection, to the extent that the veteran or a non-Federal provider of care would be eligible to receive "payment" (as proposed to be defined in subsection (i) of revised section 629, discussed below) from the "third party" concerned (as also proposed to be defined in subsection (i)) for such care or services if the care or services had not been provided by a United States Government entity. Reasonable cost would be determined by the Administrator under regulations that would be required by subsection (c)(2) of revised section 629 (discussed below).

The Committee notes that section 629 as proposed to be revised does not contain the first sentence of present section 629(b), which states:

> The amount that may be recovered by the United States under subsection (a) of this section may not exceed the lesser of (1) an amount equal to the reasonable cost of the care and services furnished the veteran under this chapter, as determined by the Administrator, or (2) the maximum amount specified by the law of the State or political subdivision concerned or by any relevant contractual provision to which the veteran was a party or was subject.

In the Committee's view this language is redundant in light of the provision in subsection (a)(1) limiting recovery to reasonable cost "to the extent" that the veteran or a non-Federal provider would be eligible for payment. Such a veteran's or provider's rights would be subject to applicable State or local law as well as to the contract itself. Thus, this deletion is not a substantive change.

Paragraph (2) of subsection (a) of revised section 629: Would specify that the right to rucover under paragraph (1) applies in situations involving a non-service-connected disability where the disability--

(1) was incident to the veteran's employment and is covered under workers' compensation;

(2) was the result of an automobile accident in a State requiring automobile accident reparations insurance;

(3) was the result of a crime of personal violence in a State, or a local subdivision thereof, which provides health care to victims of such crimes in that State or subdivision; or

(4) was incurred by a veteran who has no service-connected disability and who is entitled to health care or payment of the expenses of such care under a "health-plan contract" (as proposed to be defined in subsection (i) of revised section 629 (discussed below)), such as a health-insurance policy.

Paragraph (3) of subsection (a) of revised section 629: Would provide, with reference to a recovery by the United States from a third party under a health-plan contract containing a requirement for a deductible or copayment by the veteran, that the veteran's not having paid the deductible or copayment with respect to VA care or services does not preclude the recovery and that the amount that may be recovered would be reduced by the appropriate unpaid deductible or copayment amount, or both.

Paragraph (1) of subsection (b) of revised section 629: Would provide that the United States is subrogated to any right or claim that the veteran or the veteran's personal representative, successor, dependent, or survivors might have against a third party -- such as an insurance carrier -- in connection with a recovery under subsection (a) (discussed above).

Paragraph (2) of subsection (b) of revised section 629: Would provide that the United States, in order to enforce its right of subrogation (under paragraph (1) of this subsection (discussed above))

(1) may intervene or join in any legal action brought against a third party by the veteran or the veteran's personal representative, successor, dependents, or survivors, and (2) may institute and pursue legal action independently if no such legal action were instituted within 180 days after the VA began to furnish the care involved and the United States has given 60 days' notice to the veteran (or the veteran's representative or successor) of its intention to institute legal proceedings.

Paragraph (1) of subsection (c) of revised section 629: Would expressly authorize the Administrator to compromise, settle, or waive any claim which the United States has under this section. All pertinent provisions of Federal law, such as the Federal Claims Collection Act, would apply.

Subparagraph (A) of paragraph (2) of subsection (c) of revised section 629: Would require the Administrator, after consulting with the Comptroller General of the United States, to prescribe regulations for determining the reasonable cost of care and services for which recovery may be sought under this section. Any determination of such costs would be made in accordance with the regulations so prescribed.

Subparagraph (B) of paragraph (2) of subsection (c) of revised section 629: Would require that the regulations issued pursuant to subparagraph (A) of this paragraph (discussed above) provide that the reasonable cost of care and services sought to be recovered from a third party under a health-plan contract (such as a health insurance carrier) could not exceed an amount equal to the prevailing rate that the third party could demonstrate it would pay, under comparable health-plan contracts, for the care and services in non-Federal health care facilities in the same geographic area.

Subparagraph (C) of paragraph (2) of subsection (c) of revised section 629: Would require the Comptroller General -- not later than 45 days after the Administrator (1) first prescribes regulations relating to the reasonable cost of VA care and services, or (2) prescribes any amendments to those regulations -- to submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing the Comptroller General's comments on and recommendations regarding the regulations or amendments.

Subsection (d) of revised section 629: Would provide that, in the case of any contract or agreement entered into by the Administrator with a person under section 3718 of title 31 (relating to contracts by the heads of Federal agencies for debt-collection services, for services for the collection of indebtedness owed the United States under section 629 as amended) the contract or agreement would be required to provide that, with respect to such collection services, the person would be subject to section 3301 of title 38 (relating to the confidentiality of general VA records relating to veterans and others claiming VA benefits) and section 4132 of such title (relating to the confidentiality of certain VA medical records).

Subsection (e) of revised section 629: Would provide that a veteran (1) may not, by virtue of this section, be denied VA health care, and (2) shall not, by virtue of this section, be required to make any copayment or deductible payment in order to receive VA care. This provision would not, of course, relieve a veteran with income over $25,000 from having to pay the "coinsurance" amounts applicable under paragraphs (1)(C) and (2)(C) of section 610(a) of title 38 (as proposed to be amended by sections 1101 and 1102 of the Committee provisions (discussed above)).

Subsection (f) of revised section 629: Would provide that no law of any State or subdivision of a State and no provision of any contract or agreement would operate to prevent recoveries under this section or with respect to care or services furnished under section 611(b) of title 38, relating to the VA's authority to provide, and charge for, care and services to other than eligible veterans in emergency situations.

Subsection (g) of revised section 629: Would provide that recoveries pursuant to this section are to be deposited in the United States Treasury as miscellaneous receipts. This provision codifies the current practice under present section 629, which does not specify the disposition of amounts collected thereunder.

Subsection (h) of revised section 629: Would provide that, where recovery is being sought for the cost of VA care for a veteran who is a health-plan beneficiary, the VA medical records of that veteran would be available to representatives of the health plan -- subject to conditions prescribed by the Administrator to protect the confidentiality of the records -- for the purpose of permitting the plan to verify that the care or services were furnished and that the provision of such care and services meets criteria (such as a second-opinion or other utilization-review requirement) generally applicable under the health-plan contract.

Subsection (i) of revised section 629: Would define the terms "health-plan contract", "payment", and "third-party" for the purpose of this section.

"Health-plan contract" would mean an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of health services are paid. The Committee intends this definition to be construed broadly so as to achieve broad coverage under this section with respect to the types of health plans under which recoveries and collections may be sought.

"Payment" would include, but not be limited to, reimbursement and indemnification, the terms used in present section 629 in the same context that "payment" is used in section 629 as proposed to be revised.

"Third party" would mean a State or political subdivision of a State, an employer, an employer's insurance carrier, automobile accident reparations insurance carrier, or a person obligated to provide, or to pay the expenses of, health services under a health-plan contract. However, the definition would specifically exclude an insurance program described in section 1811 of the Social Security Act (Medicare hospital insurance) or established by section 1831 of that Act (Medicare supplementary medical insurance) or a State plan for medical assistance approved under title XIX of that Act (Medicaid).

Subsection (b) of section 1111 would provide that the amendments made to section 629 by subsection (a) of this section of the Committee provisions would generally apply to care and services provided on or after the date of enactment of this Act, but that the amendments would not apply in the case of a health-plan contract entered into before the enactment date and not modified or renewed after that date. In the case of a health-plan contract entered into before the enactment date but modified (including any change in premium or coverage) or renewed after that date, the amendment would apply with respect to the plan as of the day after the date of modification or renewal and with respect to care and services provided after the date of modification or renewal.

Subsection (c) of section 1111 would require the Administrator to report to the Committees on Veterans' Affairs of the Senate and House of Representatives (1) not later than 6 months after the date of enactment of this Act, on the process for and results of the implementation of the amendments made by subsection (a) of this section of the Committee provisions; and (2) not later than February 1, 1987, and February 1 of each year thereafter, on the process and results of implementation with respect to the most recent full fiscal year preceding the due date for the report.

PART C -- LIMITATION ON INCREASE IN RATES OF VETERANS' ADMINISTRATION COMPENSATION

Section 1121

Would prohibit the enactment of legislation increasing any of the rates of benefits under chapter 11 of title 38, United States Code, relating to disability compensation paid to service-connected disabled veterans, or under chapter 13 of title 38, relating to dependency and indemnity compensation (DIC) paid to the survivors of those who die from service-connected causes, if such legislation would increase any such rates by more than 3.7 percent or would result in costs of more than $311 million in budget authority or $280 million in outlays in fiscal year 1986. These dollar amounts reflect the Congressional Budget Office's estimate of the cost of a 3.7-percent increase effective December 1, 1985.

The Committee notes that the economic assumptions underlying the First Concurrent Resolution on the Budget for FY 1986 (S.Con.Res. 32) are those of the Administration. Thus, the budget resolution assumes that the indexed cost-of-living adjustment (COLA) that will automatically be made in the rates of Social Security benefits and need-based VA pension (pursuant to section 215(i) of the Social Security Act (42 U.S.C. 415(i)) and section 3112(a) of title 38, respectively), effective December 1, 1985, will be 4.1 percent, the percentage projected by the Administration in February 1985, when the Budget for FY 1986 was submitted. In keeping with Veterans' Affairs Committee and Congressional practice over the past several years, the budget resolution also assumes the enactment of a compensation/DIC COLA at the same percentage as the Social Security/VA pension COLA.

However, the Administration's latest estimate (in its August 1985 mid-session review) of the Social Security/VA pension COLA is 3.6 percent, and the current Congressional Budget Office estimate is 3.7 percent. Based on these recent estimates, the Committee believes that it will be able, within the 3.7-percent and cost limitations noted above, to carry out with respect to the FY 1986 compensation/DIC rate COLA its longstanding policy that compensation/DIC rate COLAs should be provided at the same percentage as the automatically-indexed COLAs in Social Security and VA pension benefits.

CHANGES IN EXISTING LAW MADE BY LEGISLATIVE PROVISIONS RECOMMENDED BY THE COMMITTEE

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by legislative provisions recommended by the Committee are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

Sec.
601. Definitions.
602. Presumption relating to psychosis.
603. Contract hospital care and medical services.

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

610. Eligibility for hospital, nursing home, and domiciliary care.
611. Care during examinations and in emergencies.
612. Eligibility for medical treatment.
612A. Eligibility for readjustment counseling and related mental health services.
612B. Payment in connection with hospital and nursing home care and medical services.
612C. Priorities in furnishing hospital, nursing home, and domiciliary care and medical services.
613. Medical care for survivors and dependents of certain veterans.
614. Fitting and training in use of prosthetic appliances; seeing-eye dogs.
615. Tobacco for hospitalized veterans.
616. Hospital care by other agencies of the United States.
617. Invalid lifts and other devices.
618. Therapeutic and rehabilitative activities.
619. Repair or replacement of certain prosthetic and other appliances.
620. Transfers for nursing home care; adult day health care.
620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities; pilot program.

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Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

(1) The term "disability" means a disease, injury, or other physical or mental defect.

(2) The term "veteran of any war" includes any veteran of the Indian Wars, or any veteran awarded the Medal of Honor.

(3) The term "period of war" includes each of the Indian Wars.

(4) The term "Veterans' Administration facilities" means—

(A) facilities over which the Administrator has direct jurisdiction; *and*

(B) Government facilities for which the Administrator [contracts; and

[(C) private facilities for which the Administrator contracts when facilities described in clause (A) or (B) of this paragraph are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required in order to provide (i) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service; (ii) medical services for the treatment of any disability of a veteran described in clause (1)(B) or (2) of the first sentence, or in the third sentence, of section 612(f) of this title or of a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in facilities described in clauses (A) and (B) of this paragraph; (iii) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a facility described in clause (A) or (B) of this paragraph until such time as the veteran can be safely transferred to any such facility; (iv) hospital care for women veterans; (v) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the forty-eight contiguous States, except that the annually determined hospital patient load and incidence of the provision of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and private facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by the Veterans' Administration within the forty-eight contiguous States, but the authority of the Administrator under this subclause (except with respect to Alaska and Hawaii) shall expire on September 30, 1985, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico and to the Virgin Islands of the restrictions in this subclause with respect to hospital patient loads and incidence of provision of medical services; or (vi) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent Veterans' Administration outpatient clinics to obviate the need for hospital admission.

[In the case of any veteran for whom the Administrator contracts to provide treatment in a private facility pursuant to the provisions of this paragraph, the Administrator shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.] *contracts.*

(5) The term "hospital care" includes—

(A)(i) medical services rendered in the course of the hospitalization of any veteran, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title;

(B) such mental health services, consultation, professional counseling, and training for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of a veteran or dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title; and

(C)(i) medical services rendered in the course of the hospitalization of a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title, and (ii) travel and incidental expenses for such dependent or survivor under the terms and conditions set forth in section 111 of this title.

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 610 and 612 of this title, optometric and podiatric services (in the case of a person otherwise receiving care or services under this chapter), preventive health-care services as defined in section 662 of this title, and (except under the conditions described in section 612(f)(1)(A) of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Administrator determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(i) of the service-connected disability of a veteran pursuant to section 612(a) of this title, and

(ii) in the discretion of the Administrator, of the non-service-connected disability of a veteran eligible for treatment under section 612(f)(1)(B) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of [1] dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title). For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title shall be eligible for the same medical services as a veteran.

(7) The term "domiciliary care" includes necessary medical services and travel and incidental expenses pursuant to the provisions of section 111 of this title.

(8) The term "rehabilitative services" means such professional, counseling, and guidance services and treatment programs (other than those types of vocational rehabilitation services provided under chapter 31 of this title) as are necessary to restore, to the maximum extent possible, the physical, mental, and psychological functioning of an ill or disabled person.

(9) The term "non-Veterans' Administration facilities" means facilities other than Veterans' Administration facilities.

§ 602. Presumption relating to psychosis

For the purposes of this chapter, any veteran of World War II, the Korean conflict, or the Vietnam era who developed an active psychosis (1) within two years after his discharge or release from the active military, naval or air service, and (2) before July 26, 1949, in the case of a veteran of World War II, before February 1, 1957, in the case of a veteran of the Korean conflict, or before May 8, 1977, in the case of a Vietnam era veteran, shall be deemed to have incurred such disability in the active military, naval, or air service.

§ 603. Contract hospital care and medical services

When Veterans' Administration facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or of furnishing the care or services required, a requirement or an authority in section 610 or 612 of this title to furnish care or services includes a requirement or authority, as the case may be, to contract with non-Veterans' Administration facilities for the furnishing of hospital care or medical services in order to provide—

(1) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service;

(2) medical services for the treatment of any disability of (A) a veteran described in section 612(a)(1)(B) of this title, (B) a veteran described in clause (1)(B) of the first sentence, or in the third sentence (but only to the extent authorized therein), of section 612(f) of this title, or (C) a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in Veterans' Administration facilities;

(3) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health

of a veteran receiving medical services in a Veterans' Administration facility until such time following the furnishing of care in the non-Veterans' Administration facility as the veteran can be safely transferred to a Veterans' Administration facility;

(4) hospital care for women veterans;

(5) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the forty-eight contiguous States, except that the annually determined hospital patient load and incidence of the provision of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and private facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by the Veterans' Administration within the forty-eight contiguous States, but the authority of the Administrator under this subclause (except with respect to Alaska and Hawaii) shall expire on October 31, 1985, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico and to the Virgin Islands of the restrictions in this subclause with respect to hospital patient loads and incidence of provision of medical services; or

(6) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent Veterans' Administration outpatient clinics to obviate the need for hospital admission.

In the case of any veteran for whom the Administrator contracts to provide care or services in a private facility pursuant to a provision of this section, the Administrator shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.

Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

§ 610. Eligibility for hospital, nursing home, and domiciliary care

[(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to—

[(1)(A) any veteran for a service-connected disability; or

[(B) any veteran for a non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care;

[(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

[(3) a person (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, or (B), who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section;

[(4) a veteran who is a former prisoner of war;

[(5) a veteran who meets the conditions of subsection (e) of this section; and

[(6) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.]

(a)(1)(A)(i) Except as provided in division (ii) of this subparagraph, the Administrator, through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title, shall furnish such hospital care as the Administrator determines to be reasonably necessary for—

(I) a veteran for a disability rated as service connected; and

(II) any disability of a veteran who has a service-connected disability rated at 50 percent or more.

(ii) In the case of a veteran who is under incarceration, the Administrator (I) may decide not to furnish care under division (i) of this subparagraph in a Veterans' Administration facility if the Administrator determines that to do so would not be feasible in terms of the security necessary in connection with the custody of the veteran or the safety of other individuals receiving care in such facility, and (II) may furnish care under such division in a non-Veterans' Administration facility (as authorized in section 603 of this title).

(B) The Administrator, through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title, may furnish such hospital care as the Administrator determines to be reasonably necessary for—

(i)(I) a non-service-connected disability of a veteran who has a service-connected disability rated at less than 50 percent;

(II) a veteran who, but for the receipt of retired pay, would be entitled to disability compensation;

(III) a veteran who is entitled to disability compensation pursuant to section 351 of this title or, but for a suspension pursuant to such section, would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is not limited in the judgment or settlement described in such section; and

(IV) a veteran whose discharge or release from active military, naval, or air service was for a disability incurred or aggravated in line of duty;

(ii) a veteran who is a former prisoner of war;

(iii) a veteran exposed to a toxic substance or radiation, as provided in subsection (e) of this section;

(iv) a veteran of the Spanish-American War, Mexican border period, or World War I; and

(v) a non-service-connected disability of a veteran who is unable to defray the expenses of necessary care.

(C) The Administrator, through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title, may (to the extent facilities and resources are otherwise available and subject to subparagraph (D) of this paragraph) furnish such hospital care as the Administra-

tor determines to be reasonably necessary for a non-service-connected disability of a veteran who agrees to make payment to the United States under section 612B of this title in connection with such care.

(D) The Administrator may prescribe regulations under which a veteran having an annual income above an amount specified in such regulations, or an estate with a corpus above an amount specified in such regulations, would not be eligible for care under subparagraph (C) of this paragraph. For the purpose of this subparagraph, the Administrator shall determine annual income in accordance with section 503 of this title and shall count as income of the veteran any income of a veteran's family member that would be taken into account under section 521(c) of this title.

(2)(A) The Administrator, through Veterans' Administration facilities or as provided in section 620 of this title, shall furnish such nursing home care as the Administrator determines to be reasonably necessary to a veteran for a service-connected disability.

(B) The Administrator, through Veterans' Administration facilities or as provided in section 20 of this title, may furnish such nursing home care as the Administrator determines to be reasonably necessary to any veteran eligible for hospital care under subparagraphs (A) and (B) of paragraph (1) of this subsection for any disability other than a service-connected disability.

(C) The Administrator, through Veterans' Administration facilities or as provided in section 620 of this title, may (to the extent facilities and resources are otherwise available and subject to subparagraph (D) of this paragraph) furnish such nursing home care as the Administrator determines to be reasonably necessary for a veteran eligible for hospital care under subparagraph (C) of paragraph (1) of this subsection who agrees to make payment to the United States under section 612B of this title in connection with such care.

(D) The Administrator may prescribe regulations under which a veteran having an annual income above an amount specified in such regulations, or an estate with a corpus above an amount specified in such regulations, would not be eligible for care under subparagraph (C) of this paragraph. For the purpose of this subparagraph, the Administrator shall determine annual income in accordance with section 503 of this title and shall count as income of the veteran any income of a veteran's family member that would be taken into account under section 521(c) of this title.

(b) The Administrator, **[**within the limits of**]** *through* Veterans' Administration facilities, may furnish *such* domiciliary care **[**to—

> **[**(1) a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when such person is suffering from a permanent disability of tuberculosis or neuropsychiatric ailment and**]** *as the Administrator determines to be reasonably necessary to a veteran who is in need of domiciliary care if the Administrator finds, pursuant to regulations which the Administrator shall prescribe, that such veteran* is incapacitated from earning a living and has no adequate means of **[**support; and

[(2) a veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care.] *support.*

* * * * * * *

§ 612. Eligibility for medical treatment

(a)*(1)* Except as provided in *paragraph (2) of this subsection and in* subsection (b) of this section, the Administrator, [within the limits of] *through* Veterans' Administration facilities [may] *or through private facilities to the extent authorized by section 603 of this title, shall* furnish such medical services as the Administrator [finds] *determines* to be reasonably necessary *(A)* to any veteran for a service-connected [disability.] *disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service), and (B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more.* The [Administrator may] *Administrator, as part of medical services furnished under the preceding sentence, shall* also furnish to any such veteran such home health services as the Administrator finds to be necessary or appropriate for the effective and economical treatment of such disability (including only such improvements and structural alterations the cost of which does not exceed $2,500 (or reimbursement up to such amount) 6s are necessary to assure the continuation of treatment for such disability or to provide access to the home or to essential lavatory and sanitary facilities). [In the case of any veteran discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, such services may be so furnished for that disability, whether or not service-connected for the purposes of this chapter.]

(2) In the case of a veteran who is under incarceration, the Administrator (A) may decide not to furnish services under the first sentence of paragraph (1) of this subsection in a Veterans' Administration facility if the Administrator determines that to do so would not be feasible in terms of the security necessary in connection with the custody of the veteran or the safety of other individuals receiving care in such facility, and (B) may furnish services under such sentence in a non-Veterans' Administration facility (as authorized in section 603 of this title).

* * * * * * *

(f) The Administrator, [within the limits of Veterans' Administration facilities,] *through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title,* may furnish medical services for any disability on an outpatient or ambulatory basis—

(1) to any veteran eligible for hospital care under section 610 of this title (A) where such services are reasonably necessary in preparation for, or (to the extent that facilities are available) to obviate the need of, hospital admission, or (B) where such a veteran has been furnished hospital care and such medical services are reasonably necessary to complete treatment incident to such hospital care (for a period not in excess of

twelve months after discharge from in-hospital treatment, except where the Administrator finds that a longer period is required by virtue of the disability being treated); *and*

[(2) to any veteran who has a service-connected disability rated at 50 percent or more; and]

[(3)] *(2)* to any veteran who is a former prisoner of war.

The Administrator may, [also] *as part of medical services furnished under the preceding sentence,* furnish to any such veteran such home health services as the Administrator determines to be necessary or appropriate for the effective and economical treatment of a disability of a veteran (including only such improvements and structural alterations the cost of which does not exceed $600 (or reimbursement up to such amount) as are necessary to assure the continuation of treatment or provide access to the home or to essential lavatory and sanitary facilities). The Administrator [may] *may, through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title,* also furnish outpatient dental services and treatment, and related appliances, to any veteran described in clause (G) of subsection (b)(1) of this section.

(g) In the case of any veteran who is a veteran of the Mexican border period or of World War I or who is in receipt of increased pension or additional compensation or allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance, the Administrator, [within the limits of Veterans' Administration facilities,] *through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title,* may furnish the veteran such medical services as the Administrator finds to be reasonably necessary. The Administrator may also furnish to any such veteran home health services under the terms and conditions set forth in subsection (f) of this section.

(h) The Administrator shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11 of this title, or increased pension as a veteran of the Mexican border period, World War I, World War II, the Korean conflict, or the Vietnam era, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran. The Administrator shall continue to furnish such drugs and medicines so ordered to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because such veteran's annual income is greater than the applicable maximum annual income limitation, but only so long as such veteran's annual income does not exceed such maximum annual income limitation by more than $1,000.

[(i) The Administrator shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order, unless compelling medical reasons require that such care be provided more expeditiously:

[(1) To any veteran for a service-connected disability.

[(2) To any veteran described in subsection (f)(2) of this section.

[(3) To any veteran with a disability rated as service-connected (including any veteran being examined to determine the existence or rating of a service-connected disability).

[(4) To any veteran (A) who is a former prisoner of war, or (B) who is eligible for care under section 610(a)(5) of this title.

[(5) To any veteran being furnished medical services under subsection (g) of this section.]

[(j)] *(i)* In order to assist the Secretary of Health and Human Services in carrying out national immunization programs pursuant to other provisions of law, the Administrator may authorize the administration of immunizations to eligible veterans (voluntarily requesting such immunizations) in connection with the provision of care for a disability under this chapter in any Veterans' Administration health care facility, utilizing vaccine furnished by the Secretary at no cost to the Veterans' Administration, and for such purpose, notwithstanding any other provision of law, the Secretary is authorized to provide such vaccine to the Veterans' Administration at no cost and the provisions of section 4116 of this title shall apply to claims alleging negligence or malpractice on the part of Veterans' Administration personnel granted immunity under such section.

§ 612A. Eligibility for readjustment counseling and related mental health services

(a) Upon the request of any veteran who served on active duty during the Vietnam era, the Administrator shall, [within the limits of Veterans' Administration facilities,] *through Veterans' Administration facilities,* furnish counseling to such veteran to assist such veteran in readjusting to civilian life. Such counseling shall include a general mental and psychological assessment to ascertain whether such veteran has mental or psychological problems associated with readjustment to civilian life.

(b)(1) If, on the basis of the assessment furnished under subsection (a) of this section, a physician or psychologist employed by the Veterans' Administration (or, in areas where no such physician or psychologist is available, a physician or psychologist carrying out such function under a contract or fee arrangement with the Administrator) determines that the provision of mental health services to such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, [within the limits of Veterans' Administration facilities,] *through Veterans' Administration facilities,* be furnished such services on an outpatient basis under the conditions specified in clause (1)(B) of section 612(f) of this title. For the purposes of furnishing such mental health services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Veterans' Administration as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section 611(b) of this title).

(2) Mental health services furnished under paragraph (1) of this subsection may, if determined to be essential to the effective treatment and readjustment of the veteran, include such consultation, counseling, training, services, and expenses as are described in section 601(6)(B) of this title.

* * * * * * *

(e)(1) In furnishing counseling and related mental health services under subsections (a) and (b) of this section, the Administrator shall have available the same authority to enter into contracts with private facilities that is available to the Administrator (under sections **[**612(f)(2) and 601(4)(C)(ii)**]** *612(a)(2) and 603(2)(A)* of this title) in furnishing medical services to veterans suffering from total service-connected disabilities.

(2) Before furnishing counseling or related mental health services described in subsections (a) and (b) of this section through a contract facility, as authorized by this subsection, the Administrator shall approve (in accordance with criteria which the Administrator shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which the counseling or services are to be furnished.

(3) The authority of the Administrator to enter into contracts under this subsection shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

* * * * * * *

§ 612B. Payment in connection with hospital and nursing home care and medical services

(a)(1) A veteran who is eligible for care or services under section 610 or 612(f)(1) of this title because of section 610(a) (1)(C) or (2)(C) of this title may not under this subchapter be furnished hospital care, nursing home care (including such care under section 620 of this title), or medical services on an outpatient or ambulatory basis unless the veteran agrees to pay to the United States—

(A) in the case of each episode of hospital care or nursing home care, for each 60 days of care, an amount equal to the lesser of—

(i) an amount equal to the amount of the inpatient hospital deductible in effect under section 1813 of the Social Security Act (42 U.S.C. 1395e(b)) at the time such care is furnished; or

(ii) the cost of furnishing such care, as determined by the Administrator; and

(B) in the case of each visit in which medical services are furnished on an outpatient or ambulatory basis under section 612(f) of this title, an amount equal to the percentage referred to in paragraph (2) of this subsection of the estimated average cost of an outpatient visit in a Veterans' Administration facility during the fiscal year in which the services are furnished, as

determined by the Administrator pursuant to regulations which the Administrator shall prescribe.

(2) The percentage described in paragraph (1)(B) of this subsection is the percentage of reasonable charges not paid from the Federal Supplementary Medical Insurance Trust Fund pursuant to section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), not taking into account the provisions of the subclauses of such section 1833(a)(1) (42 U.S.C. 1395l(a)(1)).

(3) In any case in which the Administrator determines, pursuant to regulations which the Administrator shall prescribe, that it is not feasible to request a veteran (or other individual authorized to act on the veteran's behalf) for the veteran's (or such other individual's) agreement pursuant to paragraph (1) of this subsection prior to commencing the furnishing of care or services to the veteran, an obligation to make payments pursuant to such paragraph shall nevertheless be incurred.

(b) Any moneys collected or received by the Veterans' Administration under this section shall be deposited in the Treasury as miscellaneous receipts.

(c) For the purpose of subsection (a) of this section:

(1) The term "episode of hospital or nursing home care" with respect to a veteran means a period of consecutive days—

(A) beginning with the first day (not included in a prior episode of such care) on which such veteran is furnished hospital or nursing home care under this subchapter, and

(B) ending with the close of the first period of 60 consecutive days thereafter on each of which such veteran is not being furnished either hospital care or nursing home care under this subchapter.

(2) The term "60 days of care" means (A) in the case of a veteran who during an episode of hospital or nursing home care is furnished 60 days or less of care, up to 60 days of hospital or nursing home care (or of any combination thereof), or (B) in the case of a veteran who during an episode of hospital or nursing home care is furnished care for a number of days greater than 60, each period of hospital or nursing home care (or of any combination thereof) of 60 days and, if such number of days is not evenly divisible by 60, the remaining period of care that is less than 60 days.

§ 612C. Priorities in furnishing hospital, nursing home, and domiciliary care and medical services

(a) The Administrator shall prescribe regulations to ensure that, except in cases involving medical emergencies which pose a serious threat to life or health, priority in furnishing hospital or domiciliary care or medical services under this chapter shall be accorded to veterans in the following order:

(1) To a veteran for a service-connected disability.

(2) To a veteran with a service-connected disability rated at 50 percent or more.

(3) To a veteran who has a service-connected disability rated at less than 50 percent and as compensable in degree (including any veteran being examined to determine the existence or rating

of a service-connected disability, for the purposes of such examination).

(4) To a veteran who, but for the receipt of retirement pay, would be entitled to disability compensation.

(5) To a veteran who is entitled to disability compensation pursuant to section 351 of this title, or, but for a suspension pursuant to such section, would be entitled to disability compensation, but only if such veteran's continuing eligibility for such care is not limited under a judgment or settlement described in such section.

(6) To a veteran (A) whose discharge or release from active military, naval, or air service was for a disability incurred or aggravated in line of duty, or (B) with a disability which is service-connected but not compensable in degree.

(7) To a veteran (A) who is a former prisoner of war, or (B) who, as a result of exposure to a toxic substance or radiation is eligible for care under section 610(a)(1)(B)(iii) of this title, for care as specified in section 610(e) of this title.

(8) To a veteran of the Spanish-American War, the Mexican border period, or World War I, or who is otherwise being furnished services under section 612(g) of this title.

(9) To a veteran in receipt of pension under chapter 15 of this title.

(10) To a veteran who is unable to defray the expenses of necessary care.

(11) To a veteran being furnished care or services because of section 610(a) (1)(C) or (2)(C) of this title and who is 65 years of age or older.

(b)(1) The Administrator shall prescribe regulations to ensure that priority in furnishing nursing home care under this chapter shall be accorded in the order set forth in paragraph (2) of this subsection and, within each of the categories specified in such paragraph, in the order specified in subsection (a) of this section.

(2) The priority order referred to in paragraph (1) of this subsection is as follows:

(A) Care for a veteran in need of a level or type of nursing home care that (i) is not readily available in a nursing home care facility for which the Administrator may contract under section 620 of this title and which is located in a geographic area where it is reasonable, as determined by the Administrator, for the veteran to be furnished such care, and (ii) is available in a nursing home care facility under the jurisdiction of the Administrator.

(B) Care for a veteran in need of a level or type of nursing home care that is readily available in such a contract facility in such geographic area.

(c) The Administrator shall ensure that no guideline, regulation, or other issuance of the Veterans' Administration has the effect of encouraging, directly or indirectly, the furnishing of care or services to a veteran eligible because of section 610(a)(1)(C) or (2)(C) of this title in any fashion not fully consistent with the priorities established by this section.

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Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

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§ 622. Evidence of inability to defray necessary expenses

(a) For the purposes of sections **[**610(a)(1)(B), 610(b)(2),**]** *610(a)(1)(B)(v),* 624(c), and 632(a)(2) of this title, the fact that an individual is—

(1) eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) a veteran with a service-connected disability; or

(3) in receipt of pension under any law administered by the Veterans' Administration;

shall be accepted as sufficient evidence of such individual's inability to defray necessary expenses.

(b)(1)(A) Subject to subparagraph (B) of this paragraph and except as provided in paragraph (3) of this subsection, a veteran who does not meet one of the eligibility criteria referred to in subsection (a) shall be determined by the Administrator to be unable to defray necessary expenses for the purpose of the sections of this title referred to in such subsection if the veteran's income (as determined under paragraph (2) of this subsection) during the calendar year preceding the date of the veteran's application for care is not greater than $25,000 (or the applicable greater amount calculated under subparagraph (B) of this paragraph).

(B)(i) Whenever, after December 1, 1985, maximum annual rates of pension are increased under section 3112(a) of this title, the Administrator shall, effective on the date that the increase in such rates of pension takes effect, increase the dollar amount specified in subparagraph (A) of this paragraph as such amount was in effect immediately prior to the effective date of such increase in such rates of pension, by the same percentage as the percentage by which such rates of pension are increased.

(ii) In order to avoid hardship, the Administrator, pursuant to regulations which the Administrator shall prescribe, may, in any fiscal year, increase for a specified geographic area the income level established pursuant to subparagraph (A) of this paragraph.

(2) For the purpose of this subsection, the Administrator shall determine a veteran's income in accordance with section 503 of this title and shall count as income of the veteran any income of a veteran's family member that would be taken into account under section 521(c) of this title.

(3)(A) The Administrator shall not make a determination that a veteran is unable to defray necessary medical expenses for the purpose of the sections of this title referred to in subsection (a) of this section if the corpus of the estate of the veteran (and of the veteran's spouse and dependent children, if any) is such that, under all the circumstances (including consideration of the annual income of the veteran and of such spouse and dependent children), the Administrator finds it is unreasonable to make such determination.

(B) In evaluating the corpus of a veteran's estate for the purpose of this paragraph, the Administrator shall consider the same items

to be part of the corpus of the veteran's estate as would be so considered under section 522 of this title.

* * * * * * *

§ 629. Recovery by the United States of the cost of certain care and services

(a) [In] *(1) Subject to the provisions of this section, in* any case in which a veteran is furnished care [and] *or* services under this chapter for a non-service-connected disability [that was incurred—] *described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Administrator) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.*

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

[1] *(A) that is incurred* incident to the veteran's employment and [the disability] *that* is covered under a workers' compensation law or plan that provides [reimbursement] *for payment* for [or indemnification of] the cost of health care and services provided to the veteran by reason of the [disability,] *disability;*

[(2)] *(B) that is incurred* as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations [insurance, or] *insurance;*

[(3)] *(C) that is incurred* as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such [crime,] *crime; or*

[the United States has the right to recover the reasonable costs of such care and services from the State, or political subdivision of a State, employer, employer's insurance carrier, or automobile accident reparations insurance carrier, as appropriate, to the extent that the veteran, or the provider of care and services to the veteran, would be eligible to receive reimbursement or indemnification for such care and services if the care and services had not been furnished by a department or agency of the United States.]

(D) that is incurred by a veteran who does not have a service-connected disability and who is entitled to care (or payment of the expenses of care) under a health-plan contract.

(3) In the case of a health-plan contract that contains a requirement for a deductible or copayment by the veteran—

(A) the veteran's not having paid such deductible or copayment with respect to care or services furnished under this chapter shall not preclude recovery or collection under this section; and

(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

(b) [The amount that may be recovered by the United States under subsection (a) of this section may not exceed the lesser of (1) an amount equal to the reasonable cost of the care and services furnished the veteran under this chapter, as determined by the Administrator, or (2) the maximum amount specified by the law of the State or political subdivision concerned or by any relevant contractual provision to which the veteran was a party or was subject. The Administrator shall prescribe regulations for the determination of the reasonable cost of care and services under clause (1) of the preceding sentence, and any determination of such reasonable value by the Administrator under such clause shall be made in accordance with such regulations. Regulations under the preceding sentence shall be prescribed only after notice and opportunity for public comment.]

[(c)](1) The United States shall, as to the right provided in subsection (a) of this section, be subrogated to any right or claim that the veteran [or] (*or* the veteran's personal representative, successor, dependents, or [survivors] *survivors*) may have against a [State or political subdivision of a State, an employer, an employer's insurance carrier, or an automobile accident reparations insurance carrier.] *third party.*

(2)(A) In order to enforce any right or claim to which [it] *the United States* is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran [or] *(or* the veteran's personal representative, successor, dependents, or [survivors] *survivors*) against a [State or political subdivision of a State, an employer, an employer's insurance carrier, or an automobile accident reparations insurance carrier.] *third party.*

(B) If—

(i) no such action or proceeding [has been commenced] *is begun* within one hundred and eighty days after the first day on which care [and] *or* services for which recovery is sought were furnished to the veteran by the [Veterans' Administration] *Administrator* under this chapter, and

(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute legal proceedings,

the United States may, *after* sixty days [after] *have lapsed from* the mailing of such notice, institute and prosecute legal proceedings against the [State, political subdivision, employer, employer's insurance carrier, or automobile accident reparations insurance carrier.] *third party.*

(c)(1) The Administrator may compromise, settle, or waive any claim which the United States has under this section.

(2)(A) The Administrator, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining the reasonable cost of care or services under subsection (a)(1) of this section. Any determination of such cost shall be made in accordance with such regulations.

(B) Such regulations shall provide that in no event may the reasonable cost of care or services sought to be recovered or collected from a third-party liable under a health-plan contract exceed an amount equal to the prevailing rate that such third party can demonstrate to the satisfaction of the Administrator it would pay for the care or services under comparable health-care contracts with facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

(C) Not later than 45 days after the date on which the Administrator prescribes such regulations or any amendment to such regulations, the Comptroller General shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the Comptroller General's comments on and recommendations regarding such regulations or amendment.

(d) Any contract or agreement into which the Administrator enters with a person under section 3718 of title 31 for collection services to recover indebtedness owed the United States under this section shall provide, with respect to such services, that such person is subject to sections 3301 and 4132 of this title.

[(d)] *(e)* A veteran eligible for care [and] *or* services under this chapter *(1)* may not be denied such care and services by reason of this [section.] *section, and (2) shall not be required by reason of this section to make any copayment or deductible payments in order to receive such care.*

[(e)] *(f)* No law of any State or of any political subdivision of a State, and no provision of any contract or [agreement entered into, renewed, or modified under any State law,] *other agreement,* shall operate to prevent recovery*, or collection* by the United States [(1)] under [subsection (a) of] this section [for care and] *or with respect to care or* services furnished under [this chapter to any veteran for a non-service-connected disability, or (2) under] section 611(b) of this [title for care and services furnished under such section to an individual as a humanitarian service in an emergency case.] *title.*

(g) Any moneys collected or recovered on behalf of the United States under this section shall be deposited into the Treasury as miscellaneous receipts.

(h) Medical records of a veteran who is a beneficiary of a health-plan contract under which recovery or collection is sought under this section from the third party concerned for the cost of the care or services furnished to such veteran shall be made available, under such conditions to protect the confidentiality of such records as the Administrator shall prescribe in regulations, for inspection and review by representatives of such third party for the sole purpose of permitting the plan to verify that the care or services for which recovery or collection is sought were furnished and that the provision of such care or services meets criteria generally applicable under the contract.

(i) For purposes of this section—

(1) The term "health-plan contract" means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

(2) The term "payment" includes reimbursement and indemnification.

(3) The term "third party" means a State or political subdivision of a State, an employer, an employer's insurance carrier, automobile accident reparations insurance carrier, or a person obligated to provide, or to pay the expenses of, health services under a health-plan contract, except that such term does not include an insurance program described in section 1811 of the Social Security Act or established by section 1831 of such Act or a State plan for medical assistance approved under title XIX of such Act.

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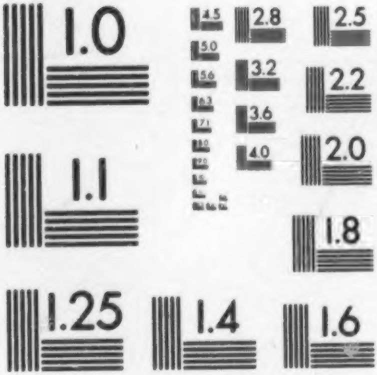
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